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An analysis of the effect of the loss of a primary physician upon a patient population

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AN ANALYSIS OF THE EFFECT OF THE LOSS OF A PRIMARY PHYSICIAN UPON A PATIENT POPULATION

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AN ANALYSIS OF THE EFFECT OF THE LOSS OF A PRIMARY PHYSICIAN UPON A PATIENT POPULATION

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CHAPTER ONE

INTRODUCTION TO THE PROBLEM

One of the most pressing problems of the practicing community physician in the United States today is that of the lack of time to care for his patients in as complete a fashion as he would wish. The corollary to this situation is the problem on the patient's side of his inability to find a doctor when one is needed. Both of these problems can in part be summarized as the fruits of the law of supply and demand, viz., there are too few doctors to care for the logarithmically accelerating number of people who are sick, or more accurately, the number of people who need to be kept healthy. However, to relegate the problem to that of a numbers game may not be the most practical, and therefore, in this case, not the wisest approach to pursue. For the local community finds little relief in plans being made in government planning centers to manufacture more physicians to meet the demand. These plans, while admirable and necessary, are blueprints for the future, but when a man or his family is sick his problem is now. It would be foolhardy to assume that any future influx of physicians (which in itself is a questionable contingency) would summarily meet the health maintenance needs of the local community. All possible avenues of utilization of present resources must be explored so that the "nowness" of the patient's, as well as the physician's, problems can be confronted with more than just a hopeful confidence in greater numbers. But to do this type of exploration toward future possibilities, it is vital to know how doctors and patients presently cope with these problems, and precisely what are the means and methods, however inadequate, that are presently used by persons seeking solutions to their "now" problems.

The case of necessary action having to be taken with few, or possibly no, alternatives at immediate disposal is the situation faced by those whose family doctor can no longer provide them with services, whether through retirement, sickness or death, or other reasons. In a situation where the doctor-patient ratio is already critical, this sudden, or even gradual, imposition of a large patient caseload can prove to be an overload that brings immense problems to the remaining physicians in the community. The physician community as a whole does not enjoy the alternatives of acceptance or rejection of this new caseload - it must somehow incorporate these patients into its services. The individual physician, however, does bear the responsibility of the difficult choice between, on the one hand, the assumption of new patients that would possibly compromise his existing patients' opportunity for care and, on the other, the denial of care to any new patients, even if they had been members of the community for years and through no fault of their own suddenly found themselves without a physician. Either one of these choices is probably inadequate to the physician, so the situation of the patient remains one of collective acceptance by the doctors as a whole but non-acceptance by the individual practitioner, a kind of medical limbo. Consequent to this patient state of suspended animation, there would probably be at best a loss of continuity, and possibly a drop in the quality or quantity of care, not even excluding a complete cessation of all care whatsoever. The increasing utilization of emergency services of nearby hospitals as "primary physicians" is creating massive problems in the delivery of this service, possibly to the point that its developing role as poly-clinic is hindering its ability to provide true emergency care adequately and swiftly. If this resource is to be used as an alternative by the patient seeking primary care, it will necessitate immediate investigation and definition of its role and possible restructuring to meet its emerging role as, indeed, a "competitor"

to the physicians in the community.

In short, the question of the disposition of a doctor's caseload when he is no longer available is a significant problem in itself, as well as being symptomatic of a more encompassing deficiency. The problem is not exclusively that of patients, that of doctors, or that of emergency services - but rather a mutual burden which needs collective action to facilitate its resolution. The situation demands immediate investigation to delineate its boundaries and define its context, and, hopefully, to suggest some possible methods of resolution and prevention that would arise from the collected data. The physicians of the community could utilize the data to determine their own needs and alternatives in the light of a sudden large increment in patient caseload and to develop a formula which would minimize the severity of the transition in the future.

The most desirable method of examination of this problem of the disposition of the patient caseload upon the loss of their primary physician would be an analysis of general trends and methods utilized in such situations. An alternative method would be the investigation of recommendations or guidelines for such situations as set down by influential agencies or those performing the role of overseer. Unfortunately, neither possibility exists since (1) there are no "general trends" in as much as each and every loss of a primary physician is handled as an individual case by a physician or family inexperienced in these matters in a community usually unprepared to cope with the problems adequately, and (2) with the past and present nature of American medicine emphasizing the freedom and individuality of the doctor, especially in the area of primary practice which still has a great proportion of solo, virtually independent, practitioners, the role of an "overseer" agency is minimal, with the existence of no or grossly

inadequate guidelines in this area. To further compound any analysis of this situation, the work done in this area has been of only quantitative significance, i.e., the numbers involved, either the number of towns without physicians, the ratios of physicians to people, etc. There has been no qualitative work, vix., the meaning of the loss of a family physician for the families involved. It is to partially fill this void and elucidate some of the problems faced by individual families that this study has been undertaken.

The nature of an investigation into the personal impact upon individual families necessitated a small scale analysis rather than a larger, but perhaps more cursory, survey. The opportunity to accomplish such a study presented itself in the situation of the Lower Naugatuck Valley in Connecticut, a semi-urban area with a large segment of suburban and a smaller proportion of rural families which had recently experienced the loss of three primary physicians, two through death and one through retirement. Each of these physicians was in solo practice and maintained a significant practice at the time of discontinuance. In the case of the doctors who died suddenly there were, of course, no prior arrangements for transition of the doctor's caseload to other physicians in the community, whereas in the situation involving the retiring doctor, there was an attempt to distribute his patients among the other doctors, but the efficacy of this is in question. While inflicting upon the community a severe loss and adding a large health burden, the loss of these primary physicians provided an appropriate vehicle to investigate the problems associated with this loss with the purpose of not only meeting present needs but ameliorating similar crises in the future.

The investigation of the situation surrounding the loss of a family physician developed as its aims:

1. To determine the mechanisms involved in the transition of the patients to new health resources

2. To determine the role of the remaining primary physicians in the area and the effect that the loss of one of their colleagues had upon them

3. To determine the meaning to the patients of the loss of their primary physician [This was, by far, the most important of the study's goals.]

This report includes:

A review of the literature, emphasizing the decline of the general practitioner, the definition of family practice, and the actual practice of the family doctor. [The prior lack of research into the problem being investigated in this study necessitates this general overview of the trends of primary practice as a more meaningful background.]

A statement of the purposes and methodology of the study, including the background of the Lower Naugatuck Valley, the genesis and development of the study, the research questions and rationale, and the research methods.

A presentation of the data developed in the study including the experience of the families, the use of the E.R., and the experience of the doctors. [Part of this chapter is presented in anecdotal form and seeks to portray the problems of the patients as seen through their own eyes.]

A summary of the findings and discussion of their significance with concurrent recommendations.

CHAPTER TWO

REVIEW OF THE LITERATURE

Before engaging in the task of analyzing a case study of the loss of a family practitioner, it is necessary to clearly define the roles, tasks, and goals of the entity with which the study concerns itself, viz.- primary or family practice. The lack of clear definition in these areas is in part responsible for the presently much discussed phenomenon of the "decline of the G.P." This case study of the loss of one family doctor investigates only a single mechanism out of the many involved in this complex relationship of populations and physician supply, and it is, of course, with this more universal problem that planners of future health preparedness must deal.

A) THE DECLINE OF THE GENERAL PRACTITIONER

The decline of the "general practitioner" as a whole is a well-studied and thoroughly investigated area, but it is interesting to note that the authoritative research on this problem became well-documented and voluminous in the 1960's. As with many problems in health the question of physician supply has been evident since before the Hippocratic era. As long as there has been ill health or "disease", there have been "patients" seeking health or "ease" from the "giver of ease," the doctor. There were never enough of these "givers of ease" to fill the demand but somehow the gaps in their ranks were swelled by men with good intentions, some common sense, and little formal education. The good intentions, common sense, and large portions of compassion were often sufficient to meet the needs of the ill, in spite of the limited intellectual resources these men had

available to them, and patients, in those times, infrequently expected more. But as the nineteenth and twentieth centuries revealed more of the intricacies of ourselves and our natural world and sharpened the focus on medicine as a "science" instead of purely "art," more was available to "ease" and more was expected by the "diseased." In response to this came two phenomena. The first followed the Flexnér Report in 1910 and resulted in the upgrading of medical education into a formal, well-structured discipline necessitating the expenditure of many years and much diligence by the prospective physician. The second was the trend that started as a trickle away from the main stream and grew to be the predominant tide itself, that is, specialization. The components of this trend are complex and lengthy, but for present purposes it is sufficient to reason that as more knowledge became available, men chose to become "experts" in smaller endeavors rather than "practitioners" in general areas. This metamorphosis of specialization into the prevailing theme took place innocuously and, indeed, had the support of all, including the general practitioner who saw in these specialists an added resource with which he could serve his patients. It was only recently that patients, physicians, and providers of health services realized how serious this transformation had been and in what proportions it had occurred. Weiskotten[65] in 1961 documented the decline of the general practitioner in the United States, while Hunt[36] noticed similar happenings in the British system. In 1963, Haggerty[30] analyzed why some physicians did not wish to become G.P.'s and noted that there were deterrent forces in all four stages of medical training: 1. pre-med school, 2. medical school, 3. hospital training, and 4. post hospital training. In 1965, Fahs and Peterson[18] did a conclusive study on primary physician supply in the upper midwest, U.S., once again

documenting the sharp decline of physician supply. Burket[8] noted the important effect of the decreased supply of G.P.'s in the whole spectrum of increasing medical needs, and emphasized the large number of specialists (about 50%) who are forced to practice "general" medicine because of the lack of primary physicians. It was Fahs and Peterson,[17] however, who clearly delineated in 1968 the exact numbers involved in the decline. This study made a special effort to avoid the misleading factors (as noted by Knowles)[40] that had previously been encountered in studying statistics on physicians' practices, viz., the validity of physicians' self-classifications, the former practice (before 1960) of classifying trainees as general practitioners, and the different numerators and denominators used for calculating ratios. The survey included all 50 states, excluding the military, and considered those physicians mainly engaged in giving primary care (general practitioners, internists, and pediatricians). It was also noted that from 1960 through 1967 the actual number of private practitioners increased, but just enough to maintain the same ratio to population. (Table I) However, the actual number of general practitioners dropped from 74,764 to 61,353 in 1967 and the ratio declined from 40.8 to 31.0 per 100,000. This meant that whereas in 1961 there was one general practitioner for every 2,448, in 1967 there was one for every 3,200. This decline in general practice, however, was not countered by an equivalent increase in those primary physicians who might share the G.P.'s burden, viz., internists and pediatricians. While the ratios of internists and pediatricians slowly increased, (Figure 1) the ratio of all those who offer most of the primary care (general practitioners, internists, and pediatricians) decreased from 56.3 to 48.9 per 100,000 in 1967, i.e., one primary physician for every 1,773 persons in 1961 to one for every 2,018 in 1967. (Figure 2) The projection of the future supply estimates the

TABLE 1

Selected Categories of U.S. Physicians, 1961-1967[17]

Group	1961	1962	1963	1964	1965	1966	1967
U.S. population:							
Estimate (thousands)	183,057	185,890	188,658	191,372	193,795	195,530	197,723
Month of estimate	July	July	July	July	July	May	June
U.S. physicians:							
Total number in practice*	223,123	224,742	250,178	263,896	266,371	274,194	276,200
Month of enumeration	Fall	October	May	June	June	June	June
Physicians in private practice:							
Number **	166,803	169,565	170,124	173,864	176,155	178,469	177,874
Rate per 100,000	91.1	91.2	90.2	90.9	90.9	91.3	90.0
General practitioners							
Number **	74,764	69,804	68,896	66,958	65,361	64,035	61,353
Rate per 100,000	40.8	37.6	36.5	35.0	33.9	32.7	31.0
Internists							
Number ***	20,574	21,037	22,274	23,452	24,138	24,651	25,688
Rate per 100,000	11.2	11.6	11.8	12.2	12.4	12.6	13.0
Pediatricians							
Number ****	7,900	8,732	8,787	9,137	9,348	9,599	9,645
Rate per 100,000	4.3	4.6	4.7	4.8	4.8	4.9	4.9
Other physicians							
Number in private practice	63,565	69,092	70,167	74,317	77,308	80,184	81,188

* Information on physicians from American Medical Association franchised company, Fisher-Stevens, Inc., Clifton, New Jersey

** Includes all physicians in private practice who, according to their self-classifications, had general practice as their only primary (full-time) specialty or had it as a primary specialty along with a secondary field.

*** Includes subspecialties of internal medicine, allergy, cardiovascular disease, gastroenterology, neurology, and pulmonary disease.

**** Includes pediatric allergy and pediatric cardiology.

FIGURE 1

Number of Internists and pediatricians in the United States in private practice per 100,000 population, 1961-67[17]

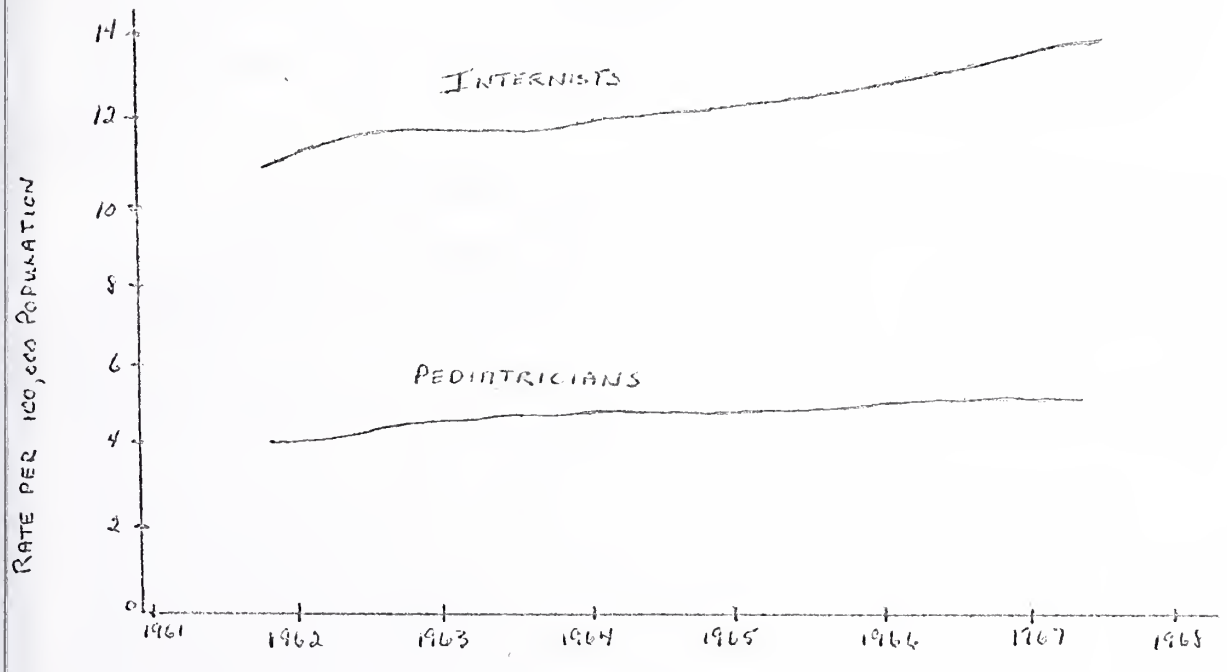
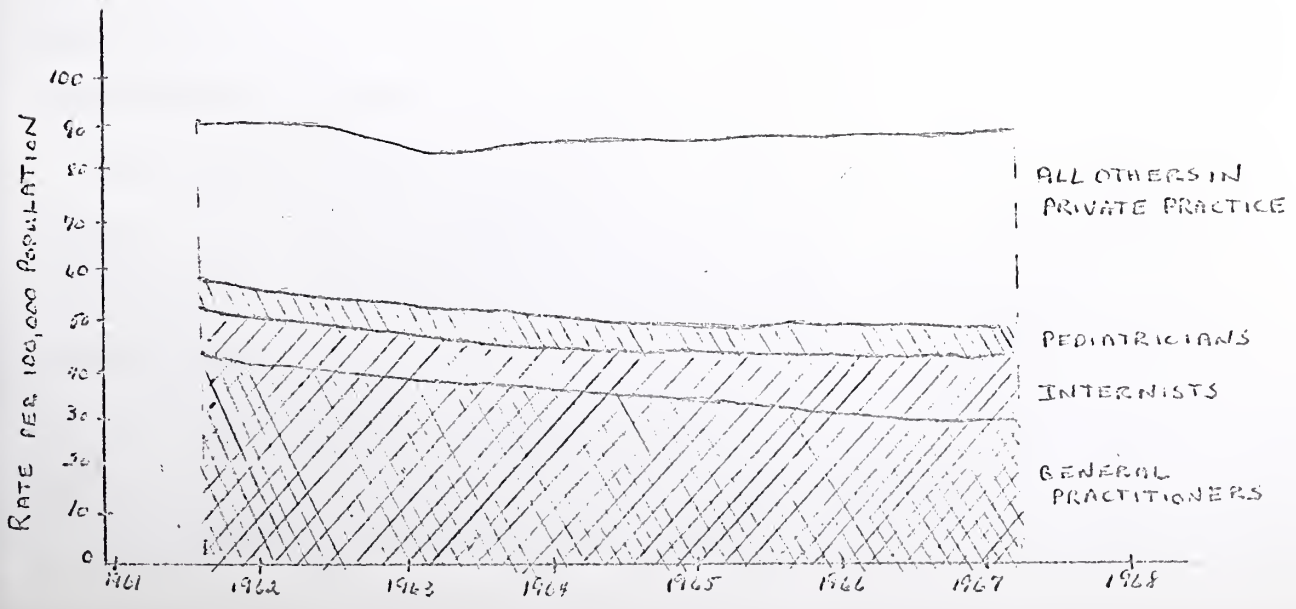


FIGURE 2

Number of physicians in the United States in private practice per 100,000 population, by type of practice, 1961-67[17]



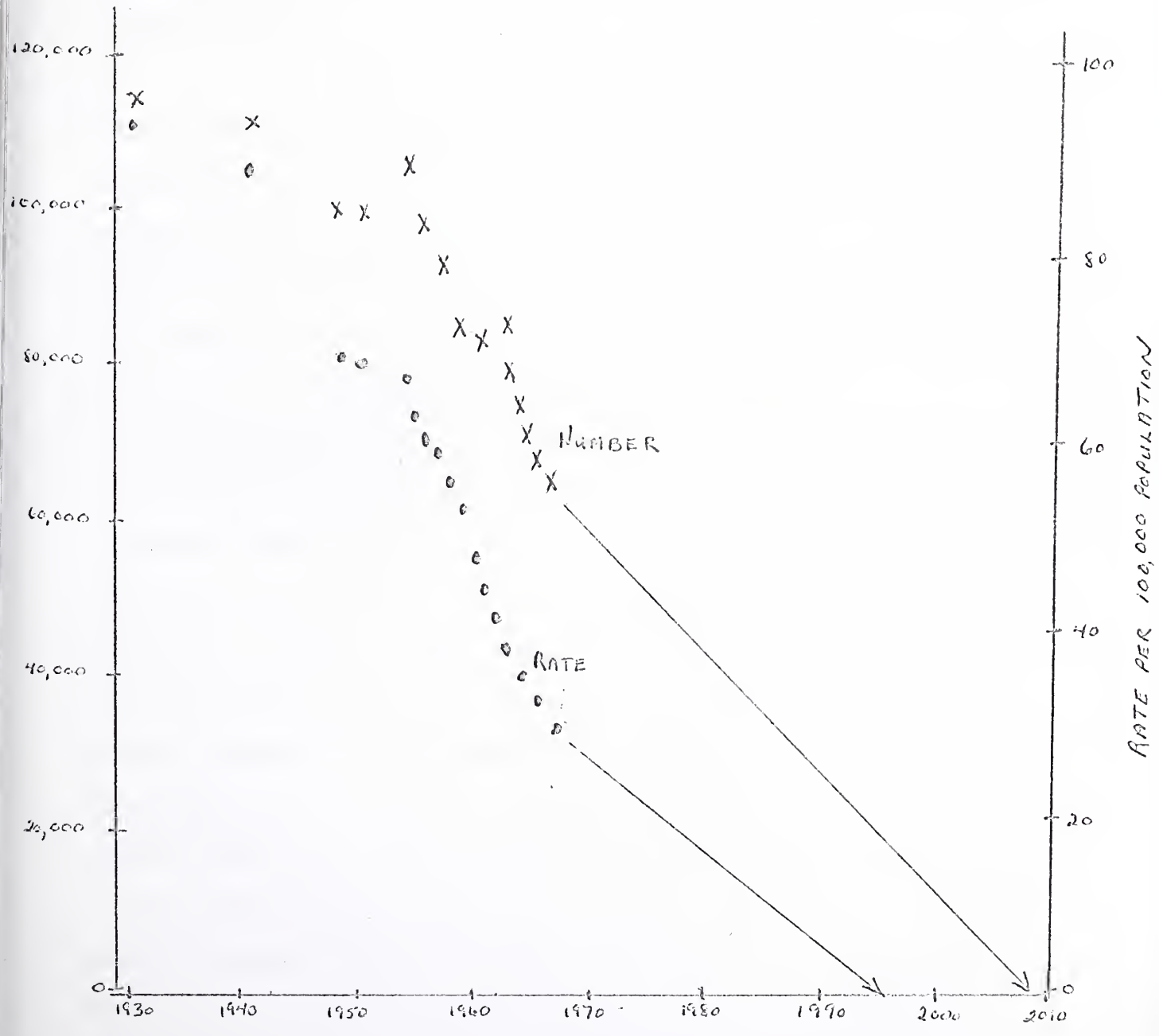
reduction of the general practitioner to negligible numbers by the year 2000 if the present trend in the G.P./ population ratio is followed. (Figure 3) If all subspecialties are included, the projected supply of primary physicians (general practitioners, pediatricians, and internists) will be slightly more than 30 per 100,000 population, or about one per 3,300 persons.

The Fahs, Peterson study was done as an addendum to the Report of the Citizens Committee on Graduate Medical Education (Millis Commission Report, 1968)[45] which again documented the decline of the G.P. and reiterated the need for comprehensive health care. The Report noted that general practitioners comprised a rapidly decreasing percentage of all doctors falling from 84% in 1931 to 37% in 1965. It was also noted that the average age of general practitioners was increasing, with 18% of G.P.'s over sixty-five years old, a much higher rate than in any other specialty. This figure of increasing mean and average age is amplified by the sparsity of young medical school graduates entering the field; in 1965 only 15% of graduating medical students were entering general practice. The Millis Report cites several factors that may be responsible for this trend: 1) the loss of prestige (the feeling in medical schools that the present day G.P. does not offer a good example of comprehensive care to students), 2) few educational opportunities to interest students in primary practice, and 3) conditions and privileges that are less attractive.

Since the publication of the Millis Report there has been a rapid increase in the number of approved residency programs for family practice, with thirty being accredited as of December, 1969. These programs sprang from a directive approved by the House of Delegates of the American Medical

FIGURE 3

Recent changes in numbers and ratio of general practitioners per 100,000 population, with future projections[17]



Association in November, 1966, which was based on the recommendations of the Report of the Ad Hoc Committee on Education for Family Practice[1] and which directed the A.M.A. Council on Medical Education to develop appropriate essentials for graduate training in family practice. These "essentials" will be reviewed further in the discussion of the "definition" of family practice.

Several other important variables also affect the supply of physicians in general and, in particular, general practitioners. Fein[19] notes that inefficient use of physicians' time and inequities in their distribution may have a greater role than a deficiency in actual numbers. The disproportionate geographic concentration of physicians in wealthy sections of the country and the resulting universal imbalance is noted by Bunker.[7]

B) THE DEFINITION OF FAMILY PRACTICE

As mentioned earlier, the exact definitions and the practical fulfillment of those definitions have been of significant consequence in the evolution of family practice. The terms general practice, family medicine, and primary medicine are often used interchangeably and have led to some confusion in the past. Indeed, prior to 1960 there were few theoretical distinctions among these terms and these were largely academic since the general, primary, or family physician was most often a result of community demand rather than a product of any specified program. Also, in many medical centers and training programs it was the prevailing mood that if a young doctor could not "get into" a specialty and continue his training in the specialty (whether for academic, financial, or personal reasons) then he would "settle for" general practice. General practice thus became looked upon as, and in certain instances was, a last choice, second-rate method of medical practice.

The 1960's, however, brought a renewed interest into the field of primary medicine and its main component at that time, the general practitioner. This interest resulted in part in the distinction between "general practice" as a form of delivering medical care, involving the episodic treatment of disease without regard to age, sex, or organ system, and "family medicine" as a branch of medical science that has as its responsibility the continuing health maintenance of the family.[13] In 1961, DeTar[15] described family practice as that aspect of medical care performed by the doctor of medicine who assumes comprehensive and continuing responsibility for the patient and his family, regardless of age. Huntley[37] emphasized the personal aspect of family care as being the essential ingredient with care by the same physician in the home, clinic, or hospital. Alpert[3] and James[38] contributed further modifications of these definitions with James emphasizing the triage responsibility of the primary physician to guide "his patient through the various specialties and then co-ordinating the fragmented findings of the specialist." James also notes that in the four stages of medicine (1) foundations of disease, 2) preclinical, 3) symptomatic, and 4) rehabilitation), it is in stages 1,2, and 4 that medical practice fails most, and in which the primary physician can be most beneficially utilized. An "official" definition was offered by the Committee on Requirements for Certification of the American Academy of General Practice (1966) which defined family medicine as

> ...comprehensive medical care in which the physician accepts continuing responsibility regardless of the age of the patient...and recognizes a relationship of continuing patient management as pertains to the individual, his family, and his environment.

A more explicit and comprehensive description was developed by the A.M.A.'s Ad Hoc Committee on Education for Family Practice (1966)[1] which envisioned the family physician as one who:

1. Serves as the physician of first contact with the patient and provides a means of entry into the health care system.

2. Evaluates the patient's total health needs, provides personal medical care in one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care.

3. Assumes responsibility for the patient's comprehensive and continuous health care and acts as a leader or coordinator of the team that provides health services.

4. Accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit.

Willard (1966)[68] emphasizes the points above and adds as a function of the family physician to be a "political force in the community for improving health care." Willard further notes (1969)[69] that in the various concepts of the primary physician he must remain much more than simply a triage officer. Indeed, the triage itself has been shown to be ably accomplished by paramedical personnel, e.g. -the physician assistant or the nurse-practitioner.

The exact role of the medical schools in producing the doctors who will fulfill the roles defined above has not been entirely resolved. White[66] proposes that the medical schools and universities are substantially responsible for the kind of medical care a society receives and, therefore, are obligated to insure the quality and quantity of the supply of primary physicians. Silver[55], on the other hand, feels that "we must

disabuse ourselves of the comfortable illusion that tinkering with education will resuscitate family practice." He proposes instead that medical practice itself must be basically reorganized, creating a number of more feasible solutions than attempting to revitalize family medicine through the medical schools. Three of these solutions, all based on eventual group practice with prepayment as a vehicle, are 1) the family practice specialist, 2) a health team coordinating physician, nurse, and social worker, and 3) a subordinate practitioner working under medical supervision. The Report of the Committee on Medical Schools and the A.A.M.C. in relation to training for family practice[50] concurred with Silver when it suggested that medical schools concentrate on devising a medical care system with the characteristics of comprehensiveness, continuity, competence, considerateness, and family orientation rather than on applying any of the particular formulas suggested by the prior reports (Millis, Ad Hoc, etc.).

C) THE PRACTICE OF THE FAMILY DOCTOR

The two previous sections dealt with the decline in numbers of the general practitioner and a theoretical definition of what the family doctor should "be". Both have alluded to, but neither described accurately, what a family doctor does. This section will attempt to review the investigations of the exact nature of the family practice as it presently exists, rather than the G.P. and his decline (the past) or the definition of the ideal family practitioner (the future).

The authoritative study of family practice was that done by Riley, Wille, and Haggerty (1969)[29] in upstate New York. The data presented in that study has been found to be consistent with similar studies of large series of practices, as well as individual case studies of one practice (including the practice under review in this study). The authors of the

New York study note that much of what has been written about family practice has been in the controversial style of what a general practitioner can not or should not do, rather than what he can and actually does do. The statement by the authors of the purpose of their study parallels closely the aims of this present study.

> "...data are needed for the development of realistic training programs in family practice and to determine medical needs of communities which are faced by declining numbers of general practitioners. It is probable that the public will continue to demand the services the G.P.'s now provide, irrespective of who provides them."

One of their many findings was that the family physician does, indeed, provide more continuity of care than the average physician, as suggested by the fact that only 15.5% of patients in this study were new to the physician, as compared with 32% of all patients who were seen in the U.S. in 1966. (There exists some controversy over the relative merits of continuity of care as noted by the questioning review by Last and White[42] and the favorable review by Lashof and Turner).[41]

The demographic data describing the New York family doctor showed the median age to be 53 (as in the Millis Report) as compared to the median age of all practicing physicians in the U.S. of 47.3 years old. While about 66% had graduated from medical school before 1946, less than 3% had graduated since 1955. As mentioned before, these statistics and those of other similar studies are ample testimony to the acceleration of the decline in the numbers of the general practitioner. (Sixty percent had more than one year postgraduate training, while only 20% had more than three years post-graduate training.) It was found also that, despite the samll number of years spent in post-graduate training, the quality of

this training was very good, and, indeed, the calibre of post-graduate training was higher for the rural G.P. than his urban counterpart (possibly because the rural physician needed to be more self-sufficient because of decreased availability of referral services in rural areas). It is interesting, in light of the competition for family doctors by areas that are drastically short of physicians, that among the main reasons given by the upstate New York family doctors for settling in their specific areas were: nonspecific medical and social community appeal (35%), encouragement by local medical or lay groups (32%), attraction of hometown (32%), trained in locale (22%), and 12% of the physicians recognized the influence of their wives in where they were to practice. These influences are similar to those noted by Parker and Tuxull.[16]

The patient characteristics of the New York study showed that 47.5% of patients were middle aged adults, 20% were under twenty years old, and 20.5% were geriatric. Females composed 58% of the active practice, while only 2% were nonwhite. While this discrepancy between the 2% nonwhite patient population of the primary physician and the 20-30% overall nonwhite population may be due to the selected population of the study (i.e. - rural or suburban vs. urban), there remains a controversy over the availability of primary physicians to nonwhite populations. Myriad reports attest to the definite disadvantage that is presented to nonwhites in finding a personal primary physician, but the study of Sheps et al[10] found that having a family doctor did not relate to socioeconomic status. They found, however, that the greatest correlation was to the number of children in a family.

The New York study also emphasizes, as did Burket[8], the increasing role in the delivery of primary care that specialists are being forced to assume. Cahal[9] found that the use of a specialist (vs. a G.P.) as a primary physician varied with geographic area, (as does the percentage of people who have any type of primary physician). For example, it was found that in large cities only 17% of the population had a personal primary physician (3% G.P., 14% specialists), medium cities had a total of 94% (68% G.P., 26% specialists), small cities had a total of 92% (79% G.P., and 13% specialists), and rural areas had a total of 83% (74% G.P., and 9% specialists). Cahal notes that the specialist most often used as a family physician was the pediatrician (51%), followed by the surgeon (27%), and internist (17%).

The location of patient family doctor contact was found by the New York study, as expected, to be mostly in the doctor's office (77%), followed by 14.5% in the hospital, 4.5% in nursing homes, schools, etc., and only 4% were home visits. This is a decrease in percentage of home visits from 40% in 1931, and those made now are primarily to the elderly and chronically ill. Hoxsie[35] points out that adequate home care has been a victim of increased patient loads and inadequate scheduling, while Ryder and Stitt[53] emphasize that home care and auxiliary home care programs should still be very much the concern of the physician.

One of the most significant findings of the New York study pertaining to this present study is that of the increased use of emergency room facilities by patients of the family doctors. Whereas Weinerman et al[64] noted that the main variable in Emergency Room use was whether or not the

patient had a private doctor, Alpert et al[2] showed that the users of the Emergency Room who have a stable relationship with their doctor form a significant portion of the E.R. users. By types of users of the E.R. the Alpert study found:

1. Stable M.D. relationship .....24 %
2. Unstable M.D. relationship 18.5%
3. Stable hospital.....20.3%
4. Unstable hospital 36.7%

The Alpert study, however, did confirm the Weinerman hypothesis that the presence of a family doctor is a significant variable in the appropriate use of the E.R. for a true emergency in an analysis of the reasons why patients came to the E.R. (in answer to "How did you happen to come to the clinic for this visit?" - see Table II).

TABLE II

REASONS FOR USE OF EMERGENCY ROOM[2]

	Families with steady doctors	Families without steady doctors
1. Referred by a private doctor	49%	2%
2. Could not get private doctor	8%	--
3. People recommend it	18%	21%
4. Because of a previous visit	23%	46%
5. E.R. is the best place to take children	14%	24%
6. The hospital is my doctor	1%	15%

In regard to the 8% of the E.R. users who did so because their doctor was unavailable, a study by Hill et al[32] showed that in a series of patients of family doctors, 25% of the patients had recently tried to get their doctor and were unsuccessful. Of these, 40% had reasons that were

non-urgent, and 60% felt their need to be urgent. Of the substitute services they finally did procure, the main source (71%) was another doctor on call, followed by the office nurse (14%), the E.R. (6%), other (8%), and no one (1%). Fifty-one percent of the patients were definitely satisfied with the substitute service, while only 7% showed strong dissatisfaction. However, the same study was adamant in pointing out that most of the patients preferred having a family doctor, were loyal to him, and trusted him more than other doctors. The patients gave as reasons for this confidence in their doctors: 1) the doctor's knowledge of the patient and of his medical history (56%), 2) the patients' knowledge of the doctor (i.e. - "used to him") (21%), and 3) an undefined "faith" in the doctor (17%). In contrast to the reasons for using the E.R. (Table 2), the Hill study lists responses from patients on the advantages and disadvantages (by undirected answers) (Table III).

TABLE III

ADVANTAGES AND DISADVANTAGES OF A FAMILY DOCTOR[32]

	Number of patients
Advantages	
1. Family history known by family doctor	107
2. Family doctor has medical records	83
3. Family doctor is always available	72
4. Confidence in family doctor	59
5. Family doctor may be consulted for personal advice	51
6. Family doctor has more personal interest in patient	38
7. Family doctor has an informal relationship with relaxed communication	36
8. Family doctor provides sense of security	33
9. Faith in family doctor provides confidence that aids in healing	22
Disadvantages	
1. Family doctor overworked	10
2. Family doctor unavailable	9
3. Delay in hospital admission because of needed referral	8
4. Family doctor's familiarity with patients' history may lead to false diagnosis in serious illness	7

It is of interest that while the availability of the family doctor is becoming more limited, the use of the Emergency service is rapidly increasing. Solon[56] estimates that the increase in E.R. utilization will have risen by 58% from 1963 to 1974 (as compared to inpatient admissions (27%), and total outpatient visits (48%). Solon's study also found that the largest percentage of users of the Beth Israel Hospital, Boston, outpatient services were patients who had private doctors (57% vs. 13.5% and 10.9% for patients who used other outpatient services in the same hospital or non-hospital clinics for the outpatient non-emergency care). The correlation between the decreasing availability of the family physician and the increasing utilization of the E.R. does not necessarily mean that the E.R. is assuming all of the tasks of the family physician. But one area is definitely now the domain of the E.R. that used to be the responsibility of the family physician, that of the care of trauma. Solon found that 33% of E.R. visits were due to trauma (Table IV) and that as E.R. utilization increases much of the minor trauma (lacerations, sprains, etc.) that was in the past taken care of in the doctor's office is now assumed by the E.R. Comparable trauma care presently comprises about 14% of a family doctors' office practice, according to the statistics of Last and White[1] (Table V) which are similar to other analyses of conditions treated in family practice.[48,62,46,27,58] The New York study found that 66.5% of patient visits was spent giving symptomatic treatment, 25% in rehabilitation, 21% in the diagnosis of preclinical illness, and 9.9% in preventive measures[29] (more than one purpose per visit.)

Table IV[56]

DIAGNOSIS RESPONSIBLE FOR E.R. VISITS

I.	Trauma		33%
	Lacerations-	8	
	Fractures-	6	
	Sprains & strains-	6	
	Contusion & crushing	4	
	Other injuries-	9	
II.	Non-trauma		65%
	Skin & other tissue-	9	
	G.I.	8	
	Neoplasm	7	
	Respiratory	5	
	Nervous & sensory	5	
	Circulatory	5	
	Musculoskeletal	3	
	G.U.	3	
	Allergic, endocrine, metabolic&nutritional	3	
	Infective & parasitic	2	
	Sx senility & ill-defined	10	
	All other	7	

Table V[42]

TYPES OF CONDITIONS SEEN IN FAMILY PRACTICE

1.	Respiratory conditions	560
2.	Trauma (including poisoning)	302
3.	Circulatory	211
4.	Nervous & sensory	155
5.	Deliveries & complications of childbirth & pregnancy	139
6.	Allergic, endocrine, metabolic and nutritional	136
7.	G.I.	116
8.	G.U.	88
9.	Mental, psychoneurotic & personality disorder	85
10.	Musculoskeletal	78
11.	Skin & cellular tissue	74
12.	Administrative procedures	55
13.	Communicable disease	51
14.	Neoplasm	21
15.	Blood, etc.	19
16.	Congenital defects	13

An important corollary to the decreasing number of available family doctors is the increasing work-load assessed to the remaining physicians. This point is of particular importance in this present study since, as noted by Hoxsie,[35] the "inability (to limit the size of his practice) places (the physician) in the human position of refusing care to those with legitimate needs." Hoxsie recorded the frequent delays in treating serious major illness resulting from the excessive demands of a busy office, wherein a serious case may receive relatively short and superficial treatment because of a doctor's anxiety about the many people still waiting to see him. The pressure of a large practice often pushes many more time-consuming measures (e.g. - preventive efforts) out of reach as the most critical factor in a doctor's schedule becomes the time he can spend with a patient, rather than the time a patient needs. Increased volume of business also limits the physician's efficacy because it limits his time for reading, home study, educational courses, reflection on difficult cases, and time to prepare a patient or his family for stress. The actual data of the family practitioners' work load is found in several studies (Table VI).[29,61,48]

Table VI[29]

WORKLOAD OF THE FAMILY DOCTOR

	Rochester Peds.	Bergman Peds.	Altman Internists	Rochester G.P.'s
Office visits/week	117±53	102	55	140
House calls/week	15±12	-	5	7
Hospital visits/week	9±5	13	24	26
Hours worked/week	43±18	46	35	48
Telephone calls each day	23±11	22	--	10

Mean number of patients/week:

1. Upstate New York study - 181 patients/week
2. Theodore & Sutter study - 131 (office visits)-versus 95 for all MD's in Jan-May '66
3. Peterson study - 165 patients/week

The rural family doctor in the New York study worked 50.5 hours per week versus his urban counterparts' 41.5. The national figures for all practicing M.D.'s and all G.P.'s are 45.3 and 49.2, respectively, while New York internists average week consisted of 35.2 hours. The study of Hill et al[32] found that each family doctor averaged about 1000 families in his practice, each family averaging about 3.75 members altogether utilizing 10.96 office visits/year and .645 house calls/year (or 2.9 office visits/year/patient and .172 house calls/year/patient). The average number of patients of one family doctor who were in the hospital at any one time was 9. In Hill's study 86% of the families had only one doctor, while in the New York study 22% of the patients were of families who received care from more than one doctor. "Irregular" patients composed about 4.5% of the New York practice, which perhaps represents that group of patients which Solon[57] calls the "symptom-hoppers" (i.e.-from one doctor to another). Solon also differentiates between a patient's central source of care, to which he says he usually goes, and his volume source of care, the source he goes to most often.

No relationship was found between the work load of the family doctor and his age (although older doctors worked fewer hours while seeing the same number of patients) or membership in the A.A.G.P. Drury[16] did note the differential that geographic areas and their flux have upon the work load of the family doctor.

A surprising variable in work load however, was found between those physicians in group versus solo practice in the New York study. The solo doctors averaged about 47.2 hours/week, while those in group practice 53.5 hours/week. These figures can be misleading though, unless the age distribution is analyzed. While only 5% of the doctors in the study were

in group practice (all rural) (vs. 81% solo and 14% partner) there was a much greater percentage of younger men in the non-solo than in the solo practices. Therefore, since the group doctors were younger on the whole (older doctors spent less time per visit with each patient) and they were guaranteed specified time off each week the work load was actually similar for both solo and group practitioners. Perhaps the most significant aspect (for the present study) is the positive impression the New York study received of the ability of the rural family physicians to work together in providing adequate coverage during vacation time and illness. They found cross-coverage in city practice not so apparent.

This present study has as one of its goals a purpose similar to that of the New York study's aim "to determine the medical needs of communities which are faced by declining numbers of general practitioners." The problem at hand appears immense and insurmountable, i.e.-there are just not enough health personnel to meet health needs, but while these limitations on supply are attacked it is incumbent upon health planners to utilize the supply that is available in the most efficacious manner and to minimize those inefficiencies which can be deleted by adequate planning and administration.

Until now no data have been available relating to the efforts in changing the present distribution of primary physicians, efforts to modify the solo nature of primary practice, or efforts to induce cooperation among physicians regarding coverage, illness, etc. Also lacking in the literature is significant data relating to the death or retirement of

physicians, either in quantitative or qualitative perspective. The area of the disposition of a primary physician's patient caseload upon his death, retirement, or disability has been wholly unexplored in the literature. Similarly, there is a void of any published guidelines pertaining to the above, either through government agencies, or national, state, or local medical association auspices. All of these areas are in need of clarification, and the present study has as its aims the delineation of one of these areas, especially the impact upon patients of the loss of their primary physician.

CHAPTER THREE

METHODOLOGY OF THE STUDY

In this chapter will be presented the background of the Lower Naugatuck Valley, as well as the genesis and development of the study itself. The research questions and rationale will also be outlined, along with the methods used in the research including the selection of the patient sample and the derivation of the physicians' questionnaire and the patients' interview. It is of significance that at times the very effort to study the situation (and the problems encountered therein) was more revealing than the results of the study themselves.

A.) The background of the Lower Naugatuck Valley

The Valley is composed of 5 whole towns and 3 towns in part, each of which has a health officer, who is appointed by the respective mayor and is responsible to him (and only in part to the State Commissioner of Health). These health officers are M.D.'s, but since all are only part time they do not have to comply with the state law requiring Public Health training. These men are not in any way responsible to the local Medical Society which was described as a "purely social organ." The quality of the individuals serving as health officers ranges from very responsible to irresponsible, but it appears that in all cases they are subject to "political pressure" and function more as technicians in a rather perfunctory role. Most receive small stipends in the range of $1-2,000. All have publicly stated that they cannot do an adequate job because of the lack of both time and experience, and all have recommended the forming of a District Public Health Department, unifying all the

fragmentary departments into one. The Chamber of Commerce has been advocating the idea of a unified Public Health Department for over five years. The first move in this direction was initiated in 1955 when Professor Ira Hiscock of Yale's School of Public Health surveyed the area's health planning and recommended in his report[33], among other things, a unified Health Department. The recommendations, however, were tabled because of political pressures, reputedly due to the feeling on the part of the mayors that they were not sufficiently consulted or informed, and various self-interests of the municipalities which felt they would "lose" by the amalgamation. Until recently with the influence of C.D.A.P. (Community Development Action Program) coming to bear, feelings of local autonomy were very strong, especially on the political level. The source of this distrust and competitive nature is ambiguous, but some attribute it in part to such obscure phenomena as the fierce high school football rivalries that divide the Valley each year into a series of distinct and competitive hamlets. The Codes pertaining to health in the Valley are anachronistic and need to be modernized and markedly revised, a task presently underway. The result of this is that public health efforts in the Valley are minimal, and those that do exist are concerned mainly with environmental problems. The concept and embodiment of the "officer of the public health" in the Valley therefore, has not, and at present cannot be expected to be, a strong force in the problems involving personal health and medical care, of which the loss of a physician is a prime example. Several years ago the aforementioned Valley Medical Society (a subsidiary of the New Haven County Medical Society) endorsed the idea of a central health officer and sponsored

the attendance of a local primary physician at Yale's School of Public Health for one year. However, in a situation shrouded with mystery, "the public", possibly under pressure from local physicians, rejected the plan when the doctor returned after the year. The only other statement of concern for local health organization by the local Medical Society (relating to the problem under study) was discussion about six years ago about helping a general practitioner if he got sick, (e.g., by manning his office). Once again, though, nothing materialized from this.

The background that these capsules of health officers, medical society, physicians, and administrators invoke is one of an area with probably no more or no less problems than other demographically comparable areas and no more and no less motivation and ability to solve them. Their equipment is meager; there is a weak, untried political health structure, an organizationally ineffective medical society, and a group of physicians who steadfastly refuse "outside" schemes to solve the problems. Indeed, the one answer that the doctors acknowledge to be the "only" solution to the problem of the increasing scarcity of the family doctor in the Valley, viz., to recruit more physicians to the area, was heretical within the last 10-15 years. The mode of practice is predominantly solo, with what partnerships that do exist being based on a sharing of office space or similar convenience rather than a team approach to a practice.

B.) <u>The Genesis and development of the study</u>

In September, 1969, this writer met with Mr. Richard Conant, director of the Health Education Project (H.E.P.) for Griffin Hospital, which is a community hospital serving the Lower Naugatuck Valley in Connecticut.

Mr. Conant and this writer (hereafter "I") exchanged backgrounds and discussed mutual interests with the intent of exploring the advantages of the participation of a medical student with the H.E.P. at Griffin Hospital. It was concluded that such a relationship might indeed be desirable for both parties. For the H.E.P. and Griffin Hospital it would be functional as:

1. An example of a medical student working in an exchange program in Community Medicine which might arise from a Yale-New Haven-Griffin Hospital affiliation agreement
2. An instrument to establish better communication between the physicians of the community and the hospital (It was thought by Mr. Conant that a medical student would be considered more acceptable a liaison to the physician than either a hospital administrator or a health educator).
3. An entry to the research facilities of Yale University.

For myself the association might provide a functional base for a research project that would be of practical benefit to the community.

Through the auspices of the H.E.P., contact was then made with Dr. Jack Galen, a primary physician in Derby, Connecticut and Dr. Andy Boissevain, a primary physician in Seymour, Connecticut, Dr. Vincent DeLuca, Chief of Medicine and Director of Medical Education at Griffin, and Dr. Val Deduk, Chief of Surgery and Director of Ambulatory Service at Griffin.

In talking with Drs. Galen, Boissevain, DeLuca, and Deduk, it was made clear that our working thesis was that cooperation and communication between hospital and local physicians have a direct effect upon the quality of patient care, and that, at least in the viewpoint of several observers, that effect was presently not the most beneficial possible at Griffin Hospital. Since the ultimate concern is herein

assumed to be better patient care, it became more obvious that new ways of bringing about better cooperation between the local health resources had to be explored. One of the important steps in this analysis would be to investigate the problems and frustrations that local physicians found in the present system, and in this role the medical student, as "community clerk", could be a valuable instrument. Dr. Boissevain, in particular, however, pointed out the danger in "attempting to tie clouds together" and suggested the development of certain specific areas of investigation which would contribute to the larger picture as a whole without attempting to grapple with amorphous or indefinable situations. Among areas that needed research were found problems ranging from the rapidly increasing utilization of the Emergency Room and the role of the hospital as a "primary physician" to referrals from a community hospital to a medical center and the place of medical education in a community hospital-medical center affiliation. The most interesting and approachable problem seemed to be that surrounding the recent loss of two doctors who were serving the community as primary care physicians. Dr. John Casagrande had recently died unexpectedly and left a moderate sized practice. He had been practicing in a type of partnership with Dr. Wilbur Hansen and Dr. Hansen was able to assume the bulk of the patients who were doctorless in the wake of Dr. Casagrande's death. The case of the retirement of Dr. R. H. Edson, however, seemed especially demanding in that he had served an unusually large practice and his loss was deemed by the above-mentioned contacts as being a particular blow to the provision of the primary health needs of the community.

On September 15, 1969, an initial proposal was submitted to the H.E.P. and on October 2, 1970, a detailed agenda for the investigation of the problem of the loss of a primary physician was approved by the H.E.P. and the Yale Department of Epidemiology and Public Health. The situation was complex and, therefore, many possible approaches presented themselves, but it was most appropriate to determine 1) what exactly occurred, and 2) how those involved reacted to it. It appeared more practical to be concerned only with the patients of the doctor who retired, since there had been more time elapsed during which they would seek services and possibly data would be more available because there had been some attempt at transition. What had happened to Dr. Edson's caseload could best be answered by the patients themselves and this could be ascertained by the series of questions mentioned below under "Research Questions".

On October 23, the format for the project was presented to and accepted by the Griffin H.E.P. Advisory Board, composed of three community leaders and three physicians, Dr. Pagliara, a family physician, Dr. Cimmino, an ophthalmologist, and Dr. Boissevain. At this meeting, the chairman (a certified public accountant) expressed amazement that physicians may have possibly had an inadequate referral system, in that "C.P.A.'s have organized referral of charts upon a particular C.P.A.'s retirement."

In order to develop a proper background for the data referring to the Emergency Room, I spent some time with Dr. Boissevain in the Griffin Hospital Emergency Room. The impressions gained were notably from a purveyor's viewpoint, rather than that of the consumer, but probably no less valid. The Griffin E.R. is modern, spacious, pleasant, well-equipped and appointed, and well-staffed. There is one doctor on duty

at all times, rotating in eight hour shifts and selected from a voluntary pool of twenty-five local physicians. This is a new system instituted in 1969, the old system being one of compulsory twelve hour shifts for all physicians on the staff at Griffin Hospital and with small renumeration (i.e.-$50/12 hour shifts and the right to bill the patient directly vs. $150/8 hour shift in deferred annuities now).

Also, under the old system a patient was asked upon entering the E.R. if he wanted his personal physician to attend to him, and if he did, his own doctor was called to come to the E.R. (which usually entailed a long wait). If the patient did not express perference for his own doctor, the doctor on duty attended to him. Under the new system it is assumed that any patient coming to the E.R. wants the services of the physician on duty. The patient is only asked about his personal doctor at the end of the visit for the purpose of forwarding any necessary information to him. This process of forwarding information from the emergency services to the personal physician is often not practiced in emergency services in other hospitals and is a positive point in maintaining good communication between the various health resources servicing a patient. While certainly being more efficient, this new method of using only the doctor on duty in the E.R. does away with most vestiges of continuity of care in the emergency service and makes good communication even more essential. These small points of communication and continuity served to highlight the many other areas in which the E.R. found itself uncomfortable and inept in the role of primary physician. The E.R. was designed, and is presently being used, as a supplementary facility for episodic acute care which in no way can supplant the personal physician as primary provider of care. The trends in other studies

show that, especially in larger cities, Emergency facilities are being used as a primary focus of care, not as a complementary resource to the family or personal physician. Whether this had been occurring at Griffin Hospital, however, was unclear, and since attitudes towards emergency room use after Dr. Edson's retirement were an important variable in this study, it was decided to include questions in the survey which would elucidate opinions and feelings of patients concerning where they would seek different kinds of care, e.g.-traumatic, preventive, maternal, psychiatric, chronic. etc. This would serve to show a conceptualization of a "family doctor," as well as of the E.R. and other ancillary services. It would also be determined if these opinions on sources of care were affected by the retirement of their traditional family doctor. This, of course, raised the variable of length of time Dr. Edson had cared for any particular family, and the decision was made to include this as part of the demographic data in the patient interview.

On November 2, Mr. Anthony DeLuca, the hospital administrator at Griffin Hospital, was interviewed to elicit his reaction to the project. He forwarded his resistance, not to the project, but to the hope that anything could come of the project. He felt that the focus of any recommendations that might arise from the project would be directed toward the physicians, which, in his opinion, was a futile effort, i.e., "you're trying to analyze the system of an unsystematized group." Mr. DeLuca was quite adamant in his concern for the possible practical applications of the study. On November 6, another meeting of the H.E.P. Advisory Board was held at which time it was expressed by one of the

doctors that "there might be a place for group practice somewhere but probably not here (Lower Naugatuck Valley)". The same physician also expressed his feelings that graduating medical students should be forced to spend two years in general practice. On November 26, Mr. R. Conant questioned the desirability of an off-service summary by a retiring physician. In a further conversation with a local family doctor, that doctor mentioned that he got all the "important" information about new patients from their hospital records. It seemed that this was particularly inadequate in light of the fact that at Griffin at that time there was no one place with a complete record of out-patient visits for any one patient, except in the hospital's financial audits which are not available for clinical use. This meant that if a patient came into the E.R. with chest pain but was not admitted, there was no record of this complaint by alphabetical order under the patient's name since the E.R. file is kept chronologically, with no alphabetical order. If the same patient came in on another visit and was able to relate that he had been in before, the doctor would then have to go through all the E.R. visit records (about 70/day) until he got to the one regarding his patient. If the patient forgot or was unable to relate previous visits for clinical reasons, the doctor would then have no way of knowing about past visits. This evidently was deemed satisfactory by one member of the hospital staff in that Griffin "only started putting inpatient records under one file a few years ago." The same physician who stated that he got most information about new patients from old hospital records also mentioned that he gains little from doctor's records than "colds and cuts", and that, indeed, his records are mostly of this type of thing.

When asked where he kept all of his personal knowledge about patients, (i.e., those things perhaps non-clinical but equally important to the family's health or actually that knowledge and information which makes the continuity of the family doctor so vital in the first place), he replied "in my head." When asked further: 1) What happens when you get so many patients that you can't keep all the facts in your head? 2) What happens when your head is no longer available to reveal the facts? 3) What if some other doctor or other health personnel could utilize these unrecorded "facts" in the treatment of your patient?, he jokingly replied that there might be some merit in the idea of recording this kind of "soft" data. This was followed by a joke to the effect that "the next thing you know R.M.P. (Regional Medical Program) will have every patient computerized so that no matter where he goes in the state his file will be readily available at the touch of the hand." There seemed to be too little hope and too much humor in that statement.

C) Research questions and rationale

In the document developed on October 2, 1969 a number of research questions were outlined. The following list was not conclusive but served as a basis for the development of the interview schedules. (Appendices A and B)

1) Had people needed medical services since the retirement of their primary physician? In their opinion, did they need more, the same amount, or less, of the services than before?

2) Where did they go for services? (e.g. - other doctors, E.R., clinics)

3) Did the frequency with which they used the E.R. or clinics change from before?

4) How did they decide where to go for services? Was there anyone who advised them?

5) Did patients feel it was harder to get medical services after their doctor's retirement than before?

6) Did patients feel that their medical problems were covered adequately, in relation to before their doctor retired?

7) Did patients want continuity of care? If so, did they feel that they were getting good continuity now, in relation to before their doctor retired?

8) Was the transition difficult between their previous doctor and new services, if any?

9) Did patients have to wait longer for medical services now?

10) Could patients receive adequate emergency or acute care, in relation to before their doctor retired?'

11) Could patients who needed chronic long-term (e.g. - weekly visits) care, receive it adequately, in relation to before their doctor retired?

12) Was the family treated as a unit, in relation to before their doctor retired?

13) What complaints or recommendations did the patients have concerning their transition?

These questions, and the variables they sought to identify, were suggested as being helpful in defining the nature of the problem, and were in no way meant to be complete or inflexible. Also, they explored only one segment of the problem, i.e. - what has happened to the patients and how they have reacted to it. But there was also another significant viewpoint, vix., that of the physicians. As was mentioned before, the problem of supply and demand was of great concern to the patient who needed services, but it was also of tremendous interest to the physician who was striving not only to provide these services but to provide them within the best parameters that medical knowledge made available to him. The physician who attempted to: 1) give complete care to all his patients, and 2) fulfill the amorphous, but very

real, responsibility of sharing mutually with his fellow physicians the care of the total population of patients (implying, therefore, that he accepts new patients as they arise), too often found himself feeling that he was doing neither task to his own satisfaction. If this already unstable balance was taxed by a sudden influx of a large group of new patients combined with the loss of a practicing physician, the position of the remaining physicians was tenuous, at best, and disabling at the worst. It was imperative, therefore, to find out exactly how physicians did react to such a situation and what they felt would be an equitable and efficient process of distribution. To this end, an investigation of the problem would have to include a counterpart to the survey of what happened to the patients, viz. an analysis of what happened to the providers of the services and how they reacted to the added burdens. The framework for this analysis would, of course, be less formal and more flexible than the patient survey, in that the problems faced by the physician were not as easily subjected to statistical analysis. The points of inquiry, would include the "hard facts" of:

1) How many of the retiring doctor's patients asked for his services? To how many was he able to provide services?

2) Was he able to assimilate them as part of his own patient caseload?

3) Did he have sufficient old medical records to adequately care for the new patients?

4) How did he receive the new patients (i.e. - how did he happen to get the particular patients he got? Was it by chance or planned?)

5) Did the absorption of these new patients into his practice cause the reduction in time previously allotted to other functions than office hours (viz.-hospital rounds, surgery, house calls, duties in the E.R., clinics, and on committees, etc.)?

Supplementing these questions that could be answered on an objective basis, would be inquiries into areas that were not as well defined and subject to the flexible position of the particular physician. These areas would include such subjective opinions as:

1) Did the physician feel that he was overloaded to begin with, i.e.-did he feel that he had more patients than he could handle?

2) Did he feel an obligation to take on new patients in general?

3) Did he feel an obligation to take on the patients of the retiring physician, in particular?

4) Was he satisfied with the manner of transfer, if any existed?

5) If he took on the retiring doctors patients did he consider them equal (as far as priority of demands) to his previous patients? Did he consider himself "their doctor" for legal purposes but not really the true provider of their primary care?

6) What role does he feel that the hospital (E.R., clinics, etc.) presently does play in assuming responsibility for the patients of the retiring doctor? What role does he feel the hospital <u>should</u> play?

7) Does he feel that the families previously treated by the retiring physician can get adequate care other than through a similar "primary physician"?

8) What possible role does he see for an "umbrella" agency that would act both as an information center for patients seeking care and as a "sorting" or triage office to assure that they got care somewhere?

9) What other suggestions or implements would he propose as means of alleviating the situation, now and in the future?

In summary then, the research questions and rationale were designed to investigate the problems of those patients who are faced with the loss of their family doctor, with an emphasis on the methods of transition that might be possibly be improved. The second part of the study was designed to elicit the problems that were faced by the remaining primary physicians in the Valley and any feelings the doctors may have had regarding their resolution.

D) Research methods

1. Patient sample

It was estimated at that time that Dr. Edson had a larger than average or about 2000 active patients which could possibly breakdown into about 350 "family" units. Prior to his retirement Dr. Edson had "asked" his patients if they had a preference for a particular family physician among the twenty or so remaining primary physicians. Those that requested a specific physician were "assigned" to him and their records were forwarded to him, without, however, any assurance that he would assume their case. It became apparent that in some cases of patients "left" to physicians, the new doctor was able to assume some of the patients only on an emergency basis, and some not at all. To detail some of these experiences it was decided to interview a representative sample of about 10% of Dr. Edson's family units (about 35 families) inquiring about the variables suggested above. An interview with each of the primary physicians in the Valley was also planned, to delineate those variables pertaining to the physicians' role in Dr. Edson's retirement. Both of these sets of interviews were to prove to be accompanied by much frustration and eventual abandonment, due in part (in this writer's opinion) to some of the facets which make primary medicine as it is presently practiced a relatively unorganized and extraordinarily time-consuming provision of service.

During the week of October 12, Dr. Boissevain, who was of inestimable help and support during the project, contacted Dr. Edson twice by telephone at his present residence in a Southern state, both to inform him of the project and to gather more details concerning the distribution of his patients. Following this, I also called Dr. Edson twice and attempted to make arrangements to meet him on the weekend

of October 19 when he would be in Derby. This was not able to be accomplished, but from these conversations came some important data: 1) instead of the estimated 2,000, Dr. Edson's practice approached 20,000 patients (judged by the number of files in his record at retirement), 2) "about" 4-5,000 of the files were in the hands of physicians in the Valley, 3) "about" 15-18,000 files were still in Dr. Edson's possession (some still under process and litigation), 4) "many" files were burned when Edson retired because they were judged no longer active (i.e., dead or moved) by unknown criteria, 5) before his retirement (July 1, 1969), Dr. Edson placed a notice in the local newspaper for one day about one month before his retirement notifying his patients that he would be retiring and if anyone wanted a referral to contact his office before July 1, 1969, 6) those patients that contacted Dr. Edson's office and requested a certain physician had their files forwarded to that physician. It was in no way assumed by either Dr. Edson or the other physicians that the latter would assume responsibility for those patients whose files were forwarded to him. Further investigation showed that this was not made explicitly clear to the patients, many of whom assumed that they were now the patients of the doctor to whom they requested referral.

When it became obvious that Dr. Edson's files were in excess of 20,000 and in two separate batches, it was decided to forego a strict statistical analysis of a random sample which would require collation of all 20,000 files. In place of the statistical analysis, a descriptive case study approach would be utilized. The problem of sampling was immediately apparent. At first it was decided to sample a certain number of families (about 15) who were Dr. Edson's patients by drawing

from the files of the physicians in the Valley, along with an equal-sized over-sample randomly chosen from Dr. Edson's present files which would compensate for the bias of the most active patients probably asking for referral and, therefore, being in the files remaining in the Valley, and also to further elucidate the problems of those who did not benefit from the "referral" system. This selection system, by itself, was fraught with many problems, and it was abandoned in favor of a system based partially upon Dr. Edson's patients' use of the Emergency Room at Griffin Hospital and partially upon a smaller cohort of the sample drawn from the files of one physician in the Valley who received a representative portion of Dr. Edson's patients according to Dr. Edson. The form for recording Emergency Room visits includes the name of the patient's family doctor, and, therefore, it was possible to gather a list of all Dr. Edson's patients who had utilized the Emergency Room for any particular time period. It was decided to review the Emergency Room records for the six months immediately prior to Dr. Edson's retirement (January 1, 1969 to June 30, 1969) and to extract from them a list of people who had referred to Dr. Edson as their "family doctor." From this list would be selected a certain percentage of families which would then serve as a portion of the families to be interviewed.

It was arbitrarily decided to take 2/3 of the sample (20 families) from the E.R. files and 1/3 (10 families) chosen at random from the files of one physician who had received many of Dr. Edson's patients. These two groups would not be run "against" each other, with one being a "control", but it was hoped that the dual source of sample would bring a more representative sample into the study. It is significant that, because of the very problems to be studied, the "whole population" (i.e., Dr. Edson's patients) was so difficult to identify, and a sample so difficult to be drawn.

It was recognized from the beginning that this method of selection had both good and bad aspects, but it was felt to be the most adequate of available alternatives if the study was to continue at all. The good points of the "E.R." cohort were its "randomness" in not biasing toward those patients who did or did not know Dr. Edson was retiring, who did or did not manage to get their record transferred, who did or did not successfully get another family doctor, and who did or did not have difficulty in the transferral process. It did insure that the sample included families who had had recent need for medical care, probably acute but possibly non-acute. This avoided sorting out patients who had moved from the area, switched to another doctor, or died. It also avoided the immense task of acquiring and collating all of Dr. Edson's files which would be necessary if a random sample were to be drawn from them. The drawbacks to this method, however, were that biases would be engaged in selecting only people who utilized the Griffin Hospital Emergency Room and only people who needed emergency medical care in that six month period. These biases were felt to be minimal in view of the fact that virtually all the residents of the Lower Naugatuck Valley (and all of Dr. Edson's patients) viewed Griffin Hospital as their Hospital point of reference (rather than the hospitals in New Haven, Bridgeport, or Waterbury, all of which are logistically at a disadvantage in providing service to the residents of the Lower Naugatuck Valley) and that if Emergency services were needed, Griffin Hospital emergency room would have been the source. Another bias inflicted by the sample was the question of the purposes for which the selected sample utilized the Emergency Room, and for this reason attempts

were later made to determine if the distribution of the causes of use of the E.R. was similar to other studies. This did not answer, though, the question of whether those in the selected sample were "high-users" of the Emergency Services or not, and whether their use of the E.R. and possibly their use of their family physician differed from the population under study. It was hoped that these biases might be in some part balanced by the "file" cabinet drawn from the doctor's files. These were drawn from one doctor's files instead of many because of the logistical problem of drawing such a sample in light of the lack of enthusiasm for the study on the part of some of the local doctors seen later in their response to the doctors survey. This cohort would not have necessarily been E.R. users, and, therefore, were without the possible biases mentioned above, but of course they did have the bias of being only those who were successful in "getting into" a new doctor's files. The possibility of "missing" (i.e.-not including in the sample) some families who had not yet found a doctor was recognized, but it was thought that within six months virtually every family would have found a new doctor. In the presentation of the data, however, it will be noted that there are 21 families from the "E.R. cohort and 9 families from the "doctor's files" cohort because of a problem with a family dropping out of the sample and having to be replaced by a family from the other cohort. Since the 20:10 ratio was an arbitrary ratio, a change to 21:9 does not appear significant.

The data also will show that the two groups are markedly similar in the most important aspect of the study, i.e. the degree of difficulty in obtaining a new physician. In the two controlled areas in which they differ, the "doctor's file" had 6 out of 9 families (67%) use the E.R. in the same time period as the "E.R. cohort" was selected,

and in the "E.R. cohort" only two families did not consider themselves to"have a new doctor". It is interesting, however, that of the 9 families drawn from the files of the doctor, 2 families similarly did not consider themselves to "have a new doctor." From this and other data, it appears that the two cohorts are very similar and equally representative of the population under study,and will be treated as one group in most of the presentation of the data. The biases mentioned above were felt to be insignificant, but deserve recognition.

2. Physicians' questionnaire

With this milieu of professional isolationism and individualism as described above as a backdrop, the possibilities for an approach to a problem such as that facing an individual who needs a doctor were not encouraging. But several factors were more encouraging, especially the presence of the H.E.P., the positive attitude toward and confidence in Griffin Hospital on the part of the populace, the burgeoning interest led by CDAP in communities working together, and the emerging possibility of hospital administrators and local physicians working together to solve mutual problems. In order to capitalize on the possibility (and the ultimate necessity) of physician cooperation, it was decided to emphasize the doctor's input to the research data by giving to them all possible avenues to express themselves. A protocol for a physician interview was drawn up emphasizing the problems that the doctor faces in the loss of a fellow practitioner. The protocol (see Appendix A) included questions about demographic data regarding the nature of the doctor's practice, recordkeeping, Dr. Edson's retirement and the assimilation of his patients, and problems of primary care in the Valley in general. A specific effort was made to allow as much flexibility in the answering of these questions as possible with the hope that the latitude of open-ended questions would bring forth opinions that the doctors had been reticent to express before, either from lack of a forum or from disinterest. An attempt was made to personally interview each of the twenty-three primary physicians in the Valley, but this met with little success. Evidently one effect of having overworked physicians was their inability to make time for non-routine procedures, especially if it involved interviewing about possibly controversial issues.

It was soon realized that the data being garnered from the interviews was not worth the time expenditure involved in procuring them. In several instances, the doctor simply asked for the protocol form from which the questions were being taken and wrote the answers, thereby thwarting possible dialogue. However, since physician opinion was deemed so necessary, and so that any possible recommendations of the study could not be met with a "we were not consulted" claim from the physicians, the decision was made to give an interview schedule to each of the doctors to fill out and return at his own leisure. Along with the questionnaire, Dr. Boissevain attached a personal note to each doctor, explaining the nature and purpose of the study and the merit of the physician's participation in it. When the response to this was poor, another request was sent out, with no better results. The minimal data that was obtained is presented in the next section.

3. Patients' interview

Along with this development of the physician questionnaire, a similar protocol began to take structure for the patients' interview, and by November 20, this was completed. (See Appendix B) Questions focused on general demographic data on the family, general family use of medical care, the transition from Dr. Edson to new health resources, the family's use of the Emergency service, out-patient clinics, and industrial health services, and the family's opinions on use of a primary physician. It was decided to send out an introductory letter explaining the study to the patients and to be sent under the auspices of Griffin Hospital and signed by Mr. R. Conant (See Appendix C). The families to be interviewed from the "E.R. cohort" were determined by

the previously described method of pulling the records from January 1, 1969, to June 30, 1969, of all the patients using the Griffin Emergency Room who had referred to Dr. Edson as their family doctor. The aggregate came to a total of 152 separate E.R. visits which were numbered sequentially in the chronological order in which they used the E.R. (giving an even distribution over the six month period). The sample of families to be interviewed was selected by taking every fifth chronological visit and contacting the family to which the individual seen in the E.R. belonged. A total interview sample of thirty families was arbitrarily decided upon, and if any of the original twenty families (of the "E.R. cohort") contacted were unable to participate for any reason their places would be filled by taking every fifth E.R. visit, one removed from the original selection (i.e. 2,7,12,...vs.1,6,11,...). A similar procedure was performed to obtain the 10 families for the "doctor's files cohort," extracting all of Dr. Edson's patients in the "new" doctor's files which were easily retrievable since most were still separate from the main files and those that were in the main files were easily located. They were then chosen periodically as in the "E.R. cohort." An eventual total of 49 families were contacted in order to get the thirty participating families in both cohorts for the interview. The reasons for not participating of those families who were selected but did not participate are seen in Table VII. Of the 49 families selected, 30 (61%), were interviewed, and of the 37 families contacted, there was an 81% cooperation. The 5 families who refused to participate without reason represented 14% of those contacted. No valid

deduction can be make about the apparently high rate of transiency and unavailability represented here for lack of adequate statistics. The great majority of the 19 selected, but non-participating, families was from the "E.R. cohort."

TABLE VII

Reasons for Non-participation of Selected Families

1.	Family moved and unreachable	7
2.	Unreachable (usually no phone)	6
3.	Refusal to participate (no reason given)	5
4.	Refusal to participate (ill health)	1
	Total	19

For all those families who were able to and chose to participate, the interviewer met them at their residence or place of their choosing and every effort was made to: 1) explain the purpose of the study, 2) convey the confidentiality of the answers and the need for a candid approach and unbiased answers, and 3) not influence the content or tone of the answers. The interviews took place between 12/22/69 and 3/1/70, that is, between 6 and 8 months after Dr. Edson had left his practice. This was felt sufficient time for the need for medical care to have developed, and yet recent enough for recall of events that had transpired around the time of his departure.

In summary, the research goals in general were to investigate the situation surrounding the loss of a primary physician and to highlight particularly the effect that this loss had upon the patient population which he served. The ramifications of the mechanics of the retirement,

the effect upon the remaining primary physicians, the role of the Griffin Hospital Emergency Room and sources of possible improvement that would mitigate a similar loss in the future would also be explored. The experimental laboratory consisted of an area that has a slightly greater ratio of primary physicians to population than the average for the U.S. (although the former ratio is steadily decreasing) and had recently experienced the loss of several primary physicians, one of whom was the physician whose retirement was to be investigated in this study. The area itself had a weak, untried political health structure, an organizationally ineffective medical society, and a group of physicians who steadfastly refused "outside" schemes to solve the problems of health care in the area, many of which they did not recognize as "problems" but rather viewed them as the "way things are." The study received assistance from the Griffin Hospital Health Education Project, and was done with the full cooperation of the Hospital, the physicians who participated, and Dr. Edson, the physician who had retired. The patient sample was selected in part from a list compiled from the E.R. use of Dr. Edson's patients before he retired and in part from the files of one of the remaining physicians who received a large number of Dr. Edson's patients. A total of 30 families were interviewed, and questionnaires were given to the 23 remaining primary physicians in the area with a poor (35%) return rate. The research was conducted between September, 1969 and February, 1970.

CHAPTER FOUR

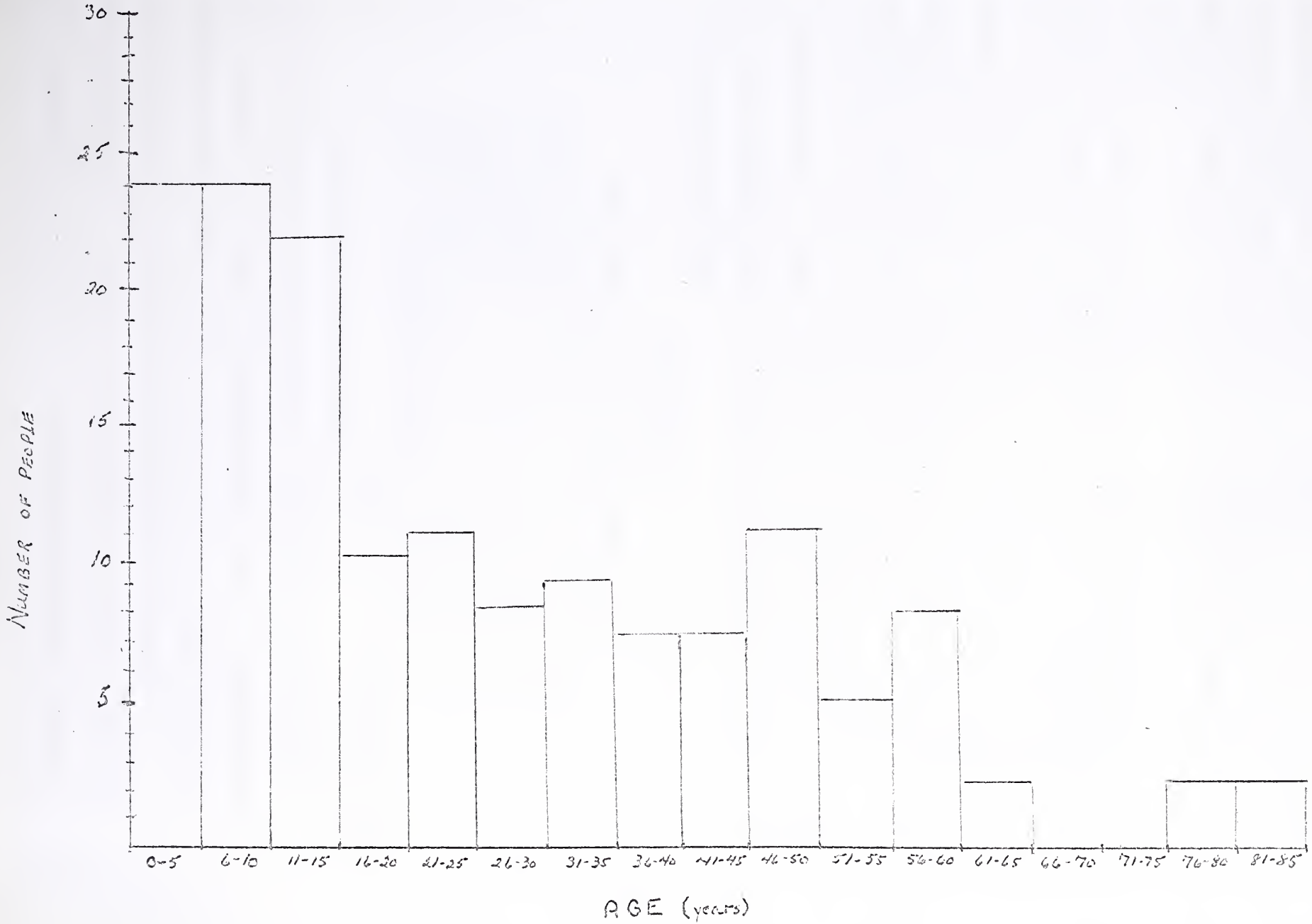
PRESENTATION OF THE DATA

A) The experience of the families

The total number of families interviewed was 30, encompassing 135 individuals, with an average family size of 4.47 persons per family. In the 9 families of the smaller cohort there were 34 individuals with similar demographic data. The demographic data of age, employment, and education indicated that the two cohorts were similar and that all the people in the sample were representative of the populace in the Lower Naugatuck Valley. The occupations of the "head of the household" showed that 70% (21 people) held "blue collar" jobs, 23% (7) had "white color" jobs, 7% (2) were retired, and, at the time of the interview, no family had a "bread-winner" who was unemployed. The breakdown of the highest level of education of the "family head" or "breadwinner" showed that 16% (5) had a grammar school education, 37% (11) had been to high school but had not received a diploma, 27% (8) had a high school diploma, 20% (6) had been to college, and none had no education at all. The age distribution of all the members of the families is as represented in Figure 4, with the greatest number, as expected, being in the childhood age group, i.e., 38% being under fifteen years of age, (vs. an actual distribution in the Lower Naugatuck Valley[52] of 30% under 15 years old), 16% between 16 and 25 (vs. 11%), 24% between 26 and 45 (vs. 29%), 20% between 46 and 65 (vs. 20%) and only 3% over 65 (vs. 10%). This indicates a higher proportion of "young" families and less older people in Dr. Edson's practice and this study than in the population at large. This is substantiated by the average number of persons in the household (which was used as the definition of "family" in this study) being 4.47 persons in this study vs. 3.30 persons in the actual

AGE DISTRIBUTION OF SAMPLE

(of all members of families)



distribution. The level of education was equivalent, with the actual median number of years of education being about 10. The actual percentage of "white collar" workers is about 16% (vs. 23% in this study,) while employment (reflecting in part an increasing number of retirees) is about 5%.

Of all those included in the survey, 129 (>96%) had been seen as "regular" patients by Dr. Edson, one had utilized Dr. Edson "at times," and 4 did not see Dr. Edson at all. (This last group came into the study as members of families in which most of the members were seen regularly by Dr. Edson.) The mean number of years that a family had utilized Dr. Edson was 15.2, with a median of 14 years. A total of fifteen people (11% out of 134) had utilized physicians other than Dr. Edson before Dr. Edson retired for the reasons reflected by Table VIII which also indicated whether the patient was referred by Dr. Edson to the physician in question.

TABLE VIII

Other Physicians Used Prior to Retirement

Obstetrician-Gynecologist	4*
General surgeon	2*
G. I. Specialist	1
Cardiologist	1*
Ophthalmologist	1
Neurosurgeon	1*
Used >1 family doctor	3
Misc. (i.e.-Edson on vacation)	2
TOTAL	15 (11% of 134)

* all referred by Dr. Edson

The three people who used more than one "family doctor" (even in what was described as Dr. Edson's "well-disciplined practice") are interesting and seem to corroborate with the 4.5% of the New York study[29] who were irregular users of one family doctor and possibly with Solon's "symptom-hoppers."[57] The total 11% who utilized a physician other than Dr. Edson prior to his retirement for the reasons specified above are

analogous to the 22% of patients whose families received care from more than one physician in the New York study.[29] The referral process involving Dr. Edson and his patients was similar to that described by Friedson[22], Piedmont[49], and Hall[31] and endured some of the problems noted by Williams et al.[21] The New York study[29] also notes rural primary physicians refer less often than their urban counterparts, implying that referral is in part a function of the availability of referral physicians (i.e.--specialists). Indeed, general practitioners refer much less (2.5%) than the average for all physicians (14%) nationally.

1. Desirability of a family physician

One important aspect of the group under study was its collective opinion of the desirability of care by a family physician as opposed to the use of specialists. 100% (30) of the spokesmen for the families indicated that they preferred using a "generalist" to a specialist, although some mentioned the possible need for specialists in "special" or "complex" problems. This, of course, is a biased sample since those being questioned had utilized one general practitioner for some length of time, implying satisfaction both with his care, and the modality of generalism which he represented. Many studies, however, have attested to the preference of a generalist as the physician of first contact by different patient populations. Cahal[9] notes that 14% of the population use specialists as their "family doctor," with a slight greater percentage using specialists in larger cities (up to 26%), while in rural areas and smaller cities less people utilized specialists. Hill et al[32] found that in a population similar to the one of the present study (i.e., patients of general practitioners) " ...most of the patients preferred having a family doctor, were loyal to him and trusted him more than other doctors."

Once again, this is the response that would be expected empirically. In the present study, many patients gave unsolicited reasons why they preferred a family physician and these will not be enumerated since not all families were queried on this point, but the reasons were similar to those given in the Hill study (Table IX).

TABLE IX

Reasons for Having a Family Doctor (undirected answers)[32]

A. General (in order)
   1. Doctor's knowledge of patient and of his medical history
   2. Patient's knowledge of doctor
   3. Patient had faith in his doctor

B. Specific (in order)
   1. Family history known by family doctor
   2. Family doctor has medical records
   3. Family doctor is always available
   4. Confidence in family doctor
   5. May be consulted for personal advice
   6. Has more personal interest in patient
   7. Informal relationship with relaxed communication
   8. Provides sense of security
   9. Faith in family doctor provides confidence that aides in healing

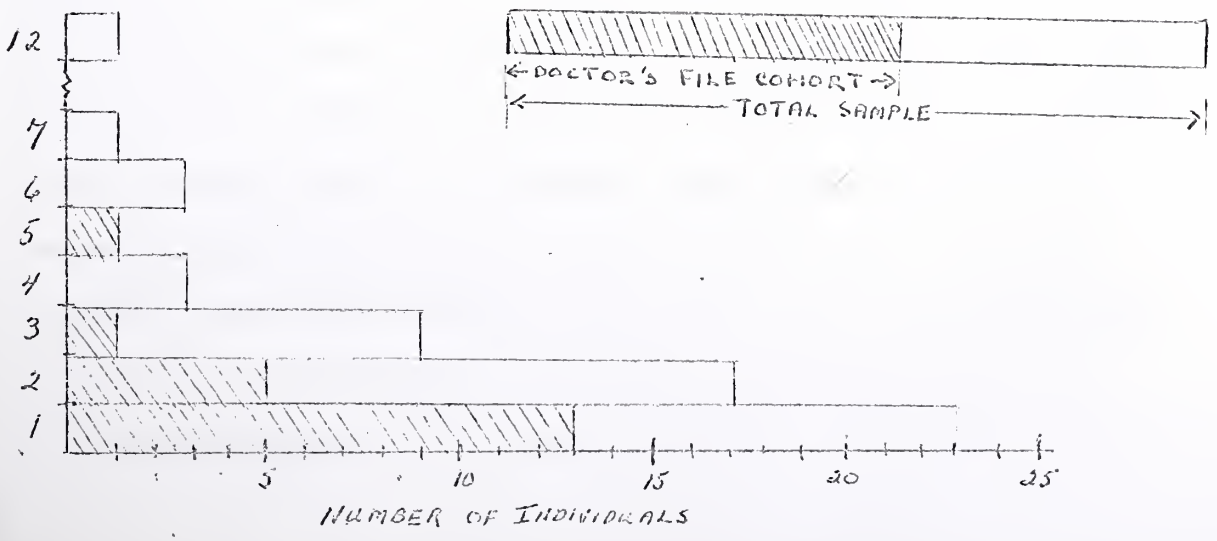
To control for reasons other than the retirement of Dr. Edson, a question was added which would indicate whether each individual in the survey needed about the same, or more or less health care since the retirement of Dr. Edson compared to prior to July 1, 1969. The results showed that 85.8% (115) needed about the same amount of care, 7.5% (10) needed more care, and 6.7% (9) needed less care. There is no objective method available for validating the accuracy of this subjective analysis by the patients, but the assessment by the individual of his own need appears to be a more accurate parameter than such scales

as Emergency Room visits, doctor visits, etc. which include other variables such as supply and demand in addition to need. (This data, therefore, implies that the need for care was not a significant variable in comparing the conditions before and after Dr. Edson's retirement.)

2. Use of other doctors after retirement

The time period chosen for the survey, i.e., six months after Dr. Edson left, was estimated to be an adequate time lapse for most families to have had some need for and possible consequent contact with, medical resources, especially a physician. To assess if this was true, it was asked for each family: 1) who had been to a physician since Dr. Edson left, 2) how many times, 3) for what reasons (acute, chronic, or preventive), and 4) which doctor (generalist or specialist). The results showed that 43.3% (58) of all the individuals in the survey had seen a physician, with the total number of visits being 132, for an average of .91 visits per individual in the survey (in 6 months), 4.4 visits per family in the survey, and 2.3 visits per individual with at least one visit. The tabulation of the number of individuals who were seen a particular number of times is shown in Figure 5.

FIGURE 5
Number of Visits Per Individual With At Least One Visit



(This data is representative of most of the data in this study in that while it is quantitative, it is probably not of comparable quantitative significance, but rather simply an indicator of what happened in this one "case study." Therefore, it is not so important whether 43.3% or 20% or 80% of the people saw a doctor but rather that 58 people in the sample made visits to a doctor in the Lower Naugatuck Valley during that time.)

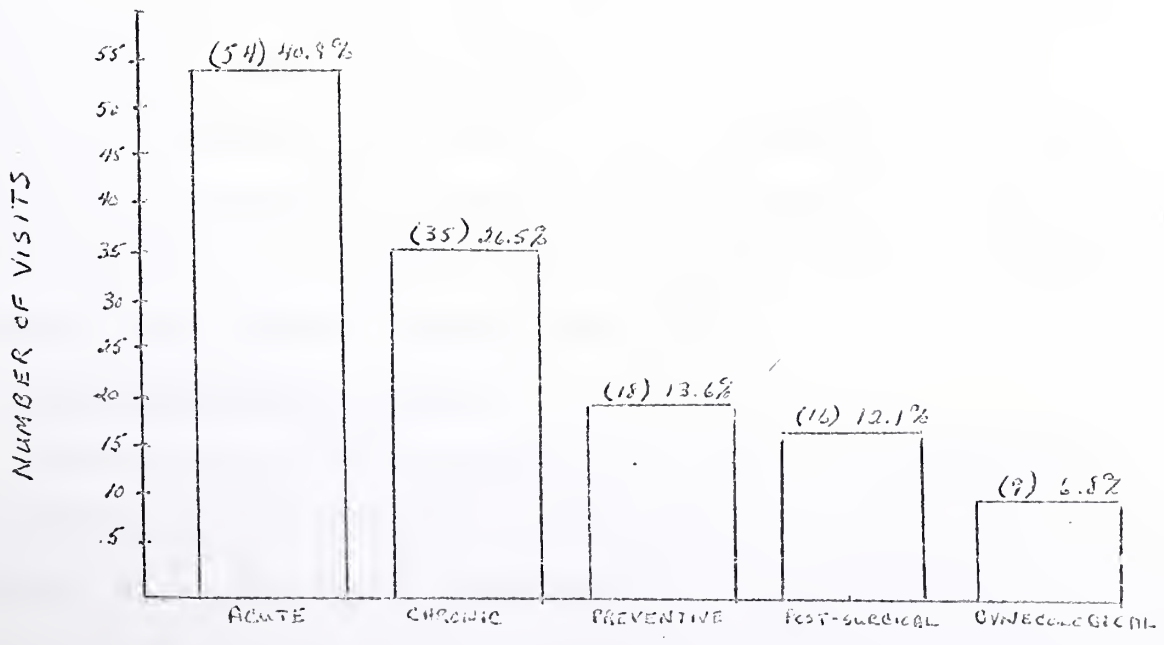
Of the 132 visits, the patients felt that in only 8 circumstances would they not have gone to see Dr. Edson if he had still been available.

In only 3 families had there been no visits to a doctor since Dr. Edson left, but these three are all interesting in that two of the three had not needed a doctor since July 1, but both had no idea of what they would do if they had needed a doctor, or, indeed, what they would do when they needed a doctor in the future. The third family was perhaps the most representative of the most severe problems that existed in this situation, since in this family all of the family members (5 people) had needed to be seen by a physician for acute illnesses and none was ever seen due to the inability of the family to locate a physician who would take them. After calling six different physicians, the family surrendered hope of obtaining a physician. The feeling they now have about doctors and the way they were handled is recorded below (Family # 13.) Although this family has survived their crisis without lasting organic damage, the feeling of despair they acquired will probably linger. It is fortunate that no major organic catastrophe happened to any of the families in the study, but it is not consoling in the light of how close the possibility of such damage came. The most probable reason for the avoidance of such a clinical disaster was

not the availability of doctors who were willing to take on families in need, (the criteria of which family was accepted by a doctor and which was not did not include an assessment of the family's need for care in most instances), but rather the presence of Emergency Service facilities at the Griffin Hospital. The E.R. however, was inadequate (justifiably so) in alleviating the anxiety and fear that possessed many families during their search for a new doctor, which in the case of several families, including Family # 13, was unsuccessful.

The reasons for the visits to the doctor since Dr. Edson left can be partitioned roughly as acute care (e.g.-lacerations, U.R.I., asthma attack), chronic care (e.g.-hypertension, periodic injections, arthritis), preventive care (e.g.-checkups and school physicals), post-surgical, and gynecological (including pregnancy). This distribution is shown in Figure 6.

FIGURE 6
Reasons for Doctor's Visits (After Retirement)



3. Continuity of care in chronic disease

One of the original hypotheses of the study was that the loss of the primary physician might occasion a break in the continuity of care in patients with chronic disease processes. In this study, 18 individuals (13.4%) considered themselves to have chronic or "special" problems requiring extended care by a physician. The problems ranged from "heart disease," asthma, hypertension, and angina, to Meniere's disease and a broken leg. Of these 18 individuals, 3 felt that there was a definite break in the continuity of care they received, and the remaining 15 felt that no significant hiatus existed. In the 3 instances where a break reportedly occurred, one man with hypertension attempted to be seen by eight physicians and was unsuccessful in doing so, a man with arthritis had difficulty getting continuation of therapeutic injections, and a woman who broke her leg just prior to Dr. Edson's retirement had difficulty with follow-up. As noted in Chapter I, there has existed at times some doubt as to whether the current interest in continuity is, indeed, in the best interest of the patient, but in terms of continuity involving chronic disease states, the summation of Last and White seems most appropriate..."there is some evidence in favor of the opposite view that under some circumstances continuity of care is not necessarily in the best interest of patients. However, these circumstances are unlikely to apply to patients who have diagnoses of cancer, heart disease, or anxiety states."[42]

4. Mechanics of the transition

Since a focus of the investigation was to detail the mechanics of the retirement, several questions relating to this were asked of the patients. It is important to note, therefore, that the perspective is

that of the patient (the consumer) rather than the purveyor. This is both by intent and circumstance, since, as explained in Chapter 2, the author was unable to examine Dr. Edson's viewpoint in depth. It was recognized at the onset, however, that if a conflict did arise between the interests of the physician and that of his patients, the emphasis on resolution must be toward the solution of the patient's problems. It was hoped, of course, that most difficulties could be resolved to both parties benefit, insomuch as they both purportedly had as a common goal the maintenance of the health of the patients in the most efficient and efficacious manner. Certain logistical situations, especially financial considerations, would, by definition, be secondary to this primary goal.

It is not known at what time Dr. Edson made the decision to retire or at what time this decision became known to his friends and colleagues. In the sample of patients, however, 10 families (33%) knew more than a month before he retired, 19 (63%) knew less than a month before he retired, and one family (3%) learned of his retirement only after he had left. The media thru which the families learned of their doctors' retirement were as follows: 1) Dr. Edson during a visit, 12 (40%), 2) newspaper, 12 (40%), 3) friends, 4 (13%), and 4) relatives, 2 (7%). All of those who found out through the newspaper read it less than a month before Dr. Edson left (since that was when the announcement was run), and of the rest 55% heard that Dr. Edson was retiring at least a month before July 1. The main source of communication other than the newspaper (which depended on whether the patients read the newspaper or not, which in this community many did) was by office visit.

Therefore, if a family had not needed medical care in the few months prior to Dr. Edson's leaving they stood a good chance of not being informed about his retirement. The newspaper announcement which was carried for one day within a month of Dr. Edson's retirement said that patients could have their records transferred to another doctor if they called Dr. Edson's office. Many patients felt that this meant that not only would their records be transferred but that their families would be assumed as patients by the physician to whom the records were transferred. In some cases, this was true; in others, it was not. Some patients made the transfer on their own initiative; others relied on the services of Dr. Edson's office, which remained open for a while after Dr. Edson had left. Some patients who had just had their records transferred by Dr. Edson's office needed care early after Dr. Edson had left, and upon inquiring, found that they were either accepted or rejected by the physician to whom their records were sent. In general, the longer the interval between Dr. Edson's leaving and the time when a family first needed medical care, the more difficult it became for them to find a physician. In retrospect then, it was quite fortuitous if a family needed care soon after Dr. Edson's leaving for at that time they stood a better chance of getting into another physician's practice. If they were "unfortunate" enough to be healthy and not need care for a longer period of time (e.g., greater than two months) they had a more difficult task in finding a successor to Dr. Edson. The reason for this discrepancy appeared to lie in the impression that many of the remaining physicians were taking Dr. Edson's patients, if at all,

on a "first come, first serve" basis, accepting patients e.g., for only two weeks after Dr. Edson left, or until they had accepted, e.g., 100 new patients from Dr. Edson.

5. Families who had difficulty

In response to several different approaches to the subject, the responses consistently indicated that about one half of the families had a "difficult time" after Dr. Edson retired. The three parameters used to quantify the "difficulty" the families had were: 1) a direct question relating to the difficulty of finding a new doctor, 2) a direct question concerning the problems with the "transition in general" and 3) the general impression rendered by the patient's narration of his experience. All three methods were consistent in showing that 14 families (47%) had a "great amount of difficulty," while 15 families did not experience this. One family claimed no problems in answer to the direct question, but still had not gotten a doctor. In almost all the cases, it was quite clear one way or the other, i.e., those who "had difficulty" had great difficulty and those who "did not" noticed few problems. There were very few marginal situations; the two groups seemed like separate poles rather than part of a continuum. The breakdown of degree of difficulty for the two different cohorts was very similar, with 5 out of 9 in the "doctor's files cohort" having "great difficulty" and 9 out of 21 having "great difficulty" in the E.R. cohort, with the contradictory case belonging to the latter. The questions referring to degree of difficulty in the way they were asked and the similarity of their responses, seem to indicate that the difficulty did not lie so much in the personalities of the physicians involved, but in the mechanism. It would have been expected that if the patients were not satisfied with the physicians they finally got

(having been used to Dr. Edson), more families would have noted that the transition in general was more difficult than finding a new physician. The fact that both responses were similar implied (perhaps, tentatively) that the problem existed primarily in acquiring a new physician rather than the patient's satisfaction with the new doctor once gotten.

Each family had a unique experience after Dr. Edson left, and beyond gauging difficulty, it is difficult to group the types of experiences. Perhaps the most accurate assessment of the situation (and certainly of the feelings of the patients) is to be seen in the unsolicited statements of the patients. Among those who had difficulty, the following statements are representative: (Numbers are submitted for family names and letters for the doctors' names with the letters A,B,C, representing different doctors in each scenario).

Family # 2

"When I heard (about Dr. Edson leaving) I cried, then I called Dr. Edson's office. I called "Dr. A's" office and our family was accepted and we had our records sent to "Dr. A." We needed Dr. A. in September and got him-since then we've had a lot of problems with Dr. A., and then Dr. B. Now we have no doctor and don't want one. We'll go to the E.R." "Is there any law against using the E.R.? That's what I'm going to do. I'm through with doctors." "If you don't have a family doctor and have to go in Griffin, you don't get any respect."

Family # 3

"We asked Dr. Edson to recommend a doctor. He wouldn't but mentioned Dr. A. We didn't know what to do and we called Dr. A's office (before Dr. Edson left) and they said that we might be seen in an emergency but they didn't know about taking us on as regular patients. We considered Dr. B. but Dr. Edson's office said he was a surgeon-G.P. and we wanted only a G.P., so we asked to have the records sent to Dr. A. Dr. Edson's office was surprised that Dr. A's office wasn't accepting any more patients, but they sent the records anyhow. We haven't needed a doctor since then, but we have no idea of who would take care of the family if we needed one. Dr. A. has our records but we don't know if we're his patients."

Family # 5

"When we heard about Dr. Edson's retirement (about one month after) we asked Dr. A. to take our family on and he said he would if the records could be sent to him. We called Dr. Edson's office which was closed and we couldn't get the records sent. In September my mother needed a doctor and called Dr. B. and he took her but she had to wait 10 days for an appointment, and we feel she needed care much quicker than that."

Family # 9

"We called Dr. Edson's office and told them to send our records to Dr. A., but when we called Dr. A.'s office in November because we needed him then, we were told we couldn't be seen because he was overloaded. They referred us to Dr. B., who accepted us and with whom we are satisfied."

It is of interest that Dr. B. is a new physician to the area about whom this family had known, but they did not want to go to him unless Dr. A. recommended him. Many other patients did not even know that Dr. B. was in the area, which is very curious in any area such as the Valley where communication is so rapid. The experience here may indicate that the statement of a doctor's availability in a newspaper or in telephone listings is inadequate to engender confidence in potential patients and that many patients will only try a new doctor upon the advice of a doctor in whom they already have confidence, or upon the positive experience of friends or relatives with that new doctor. For a new doctor coming into an area (with few previous patients in the area) or conversely for patients new to an area (without reliable contacts in the form of friends or relatives) the reliability of a physician could be gauged effectively by one of the many mechanisms of peer-review that are presently being discussed and advocated. In this situation, the review's functioning would not be so much in the way of sanctioning, but of establishing a bond of confidence between physician and potential

patient. As Klutch notes"...many of the anxieties, criticisms, and situations of conflict which arise between the medical profession and various segments of the public...stem from the failure of fractions of the organized profession to demonstrate to the public visible evidence of the capabilities they possess in evaluating and assessing physician performance..."[39]

Family # 13

"We called six doctors and we couldn't get a doctor - the family was all sick and we couldn't get a doctor...I was so mad I wanted to call the medical board, and Dr. A. said he didn't give a damn if I called the medical board, he wasn't going to make a house call. Don't these doctors take an oath to save people-then why the hell don't they?...If something had happened to our family it would have been (the doctors') fault-it's their responsibility to take care of us when we're sick. Now if we need anything, we go to the E.R., as we've been doing. At the E.R. when they ask you who you're family doctor is and you say you don't have one, they look at you like you're crazy-you've got to have your own doctor for them...It's terrible the way doctors can't make house calls, they're making more making house calls anyhow."

This last statement is not intended to be representative of all the families interviewed. Indeed, few were as histrionic and vitriolic in their condemnation of doctors in general and, in particular, the role they played in Dr. Edson's retirement. Most families viewed the problems they faced as being one of the mechanics of the situation rather than a reflection on the personalities of the physicians involved. The statement does serve to illustrate the high feelings of ill will toward doctors that exist in certain parts of the community. It is not justifiable, either, to pass off these feelings as those of recalcitrant malcontents, any more than it is to say that those who have no complaints are simply frustrated and are passively submitting to inequities. Rather, those that are quite content and those that are very angry or distraught

over the medical situation represent the two poles of a normal spectrum, rather than abnormal and irrelevant opinions. And while the source of these feelings may be the personality of those holding them, it is inadequate to ascribe them to this without an honest investigation of the possible genesis of these feelings within the system that abutts upon these personalities. It is of interest that the family holding such angry and seemingly militant views is not chronically disenfranchised in the usual sense of the term, since they are white, middle-class, and in other ways characteristic of "Middle America," but recently they had been made economically and emotionally "poor" by a three week lay-off due to a "slight stroke" to the speaker of the above angry words.

Family # 14

"Dr. Edson wouldn't recommend any new doctor. We didn't think any more of it and didn't have the records sent anywhere. I had been seeing Dr. Edson every 2-3 weeks for hypertension, and I tried about eight doctors...my blood pressure was going up, my job was in jeopardy, and I was decreasing my medication because it was running out and I couldn't get a doctor to renew it. I was very upset, climbing the walls, when after several months my husband happened to talk with Mrs. A. (wife of Dr. A.) and we were accepted by Dr. A. who got our records. It was a frightening thing not to know who to turn to when you're sick."

It seems incredible to those associated with the health system that a patient (who was, incidentally, an L.P.N.) would be so unsuccessful in obtaining vital medications from so many physicians and the tendency is to ascribe the problem, once again, to some inadequacy on her part. However, her experience was real, not contrived, and her fright is something that can easily be understood.

Family # 17

"We didn't know what to do. We heard Dr. A. was good through friends and Dr. Edson said he was good and so we had our records transferred to him. We had called Dr. A's office before and our family had been accepted. When we called Dr. A's, we were told he was away on vacation and to get another doctor or go to the E.R. because no doctor was covering. They said that there's a new rule that when a doctor is away, the patient would go to the E.R. We finally got Dr. B. and he took the whole family on."

An attempt was made to explore the patterns of coverage among the physicians in the area, but this met with limited success. There is no prevailing pattern and, to the best knowledge of the interviewer, there is no "rule" saying that the patient should go to the E.R. Several physicians cover for each other on weekends and vacations, and others have no coverage whatsoever. The attitudes and opinions of doctors regarding coverage and working with other doctors in general is a very complex and inflammatory subject. It appears that most of the doctors are able to mobilize and galvanize a cooperative effort when they feel that something threatens them either directly or indirectly (e.g.-the government or the hospital), but are not enthusiastic about organized or systematized cooperation with each other on a larger scale, fearing the omnipresent spectre of "socialization." Their interaction appears to be primarily social, although on any particular occasion where the health of a patient is in question there is little doubt that the physicians would then make every attempt to cooperate for the sake of the patient. It is the systematization of cooperation that probably would be resisted.

Family # 18

"I was told by Dr. Edson when I went for a check-up. I never would have seen the paper-it probably missed an awful lot of people. I asked Dr. Edson to refer us and he wouldn't Then I asked for the names of doctors in Seymour and was told about Dr. A. and Dr. B. We asked Dr. Edson to send our records to Dr. A.-then the last week in July we needed an appointment and Dr. A. was on vacation, so we took our son to the E.R. Then in October we needed an appointment for our son and we were told by Dr. A's office that they weren't accepting any new patients. We didn't know anything about a time limit-we figured as long as our records were accepted, we were accepted as patients... We didn't go to Dr. B. because he's left the Valley three times, for six months at a time (without coverage)...When we really needed a doctor, we didn't have one-if we hadn't have gotten Dr. C., we don't know what we'd have done."

Family # 23

"We called eight doctors (about two months after Dr. Edson left) and we couldn't get anybody. If we needed anything, we went to the E.R. for it. Then, after two months of looking we found Dr. A. in November and now he's our family doctor."

Family # 24

"My father got an arthritis shot once a month (before Dr. Edson left) and he hasn't gotten any since Dr. Edson left. He doesn't know where to go...It wasn't a matter of who you wanted, it was who you could get."

Family # 25

"It was a bad thing-all these patients who had entrusted their care to the doctor suddenly had this real big problem. I blame the hospital-it seems they should have been able to do something about it. The hospital should have a knowledge of all the doctors and it didn't fulfill it's responsibility."

Family # 26

"My cousin recommended Dr. A. and we asked Dr. Edson to send our records. When we went for a visit, we found out he wasn't taking any new patients. Now we have no idea of where our records are or where to go if we needed a doctor. We probably wouldn't have a family doctor, we'd just take whoever we'd get at the time-but I wouldn't go to the E.R., they tortured my son."

Family # 27

"It was a sudden decision, we needed a doctor quick. We didn't have any preference, so we went to Dr. A. Now we would like to have another doctor but I don't know "how" to do it. I don't know if that's against "medical ethics." What do you do-tell the one doctor you want him to transfer the records to another doctor?"

Although this problem appears to be one of personalities rather than the mechanism of transfer, it exemplifies the situation whereby even in the patient's viewpoint, the term "medical ethics" in some way connotes "doctor's rights." While it should not be the aim of any mechanism to have total satisfaction on the part of all parties (thereby eliminating the human factor), there should exist a more adequate instrument to assist the patient in negotiating the present "non-system" of health care. The many expressions on the part of patients of "having no help" "not knowing what to do," and "being alone" were not in the spirit of rugged individualism upon which free enterprise is based. It remains a moot question whether the free enterprise health "system" which is so desirable to physicians is, indeed, the source of the corporate "aloneness" of the patients. However, it becomes apparent that "medical ethics" may not be the equitable concept it is envisioned to be, if it unfolds its machinations to the benefit of the physician while presenting only unnegotiable obfuscations to the patients.

Family # 28

"Dr. Edson always made you feel comfortable and wanted; he was kind of like the old time country doctor-kind, gentle-an extraordinary doctor. Dr. Edson had Dr. Casagrande check on me, but then he (Dr. Casagrande) died. We don't have any doctor now-if we get sick I have no idea what we would do."

Although this statement is similar to the previous in its situational content, the devotion expressed by this retired couple for their family doctor seems to instill in their resigned despair at his loss a more cogent sense of helplessness and urgency. These people were too old to be angry, but not too old to be frightened. The irony of this man's

summating statement had become all too real for them. "Whoever's in charge of the doctor business should tell you where to get a doctor."

> Family # 29
> "We didn't have our records sent anywhere because at the time we didn't know any doctor-we didn't need one at the time. We don't know where our records are; we figured Dr. Edson destroyed the records when he left-they would help Dr. A. now. With my father (84 years old), I have no idea who to go to; when the time comes, we'll make the decision."

Manifest in this example is what a person "sophisticated" in health affairs would call "naivete" and "irresponsibility" on the part of the patient for not "thinking ahead." This impression of "naivete" might be ample testimony to why "those sophisticated in health affairs" may sometimes be misguided in their "handling" of the health problems of the "unsophisticated."

6. Families who did not have difficulty

The statements above are not representative of the whole sample, but only those in the "great difficulty" category. They are not intended to be used as statistical instruments, but only as the face-value expressions of people who were telling their story. It is interesting, also, to look at the experiences of those who claimed little difficulty and intriguing to speculate what possible variable distinguished the two groups, i.e., both groups were subjected to one varialbe, viz., the loss of their family doctor, but the two groups had markedly divergent results. What other variables intervened to separate those who had difficulty from those who did not, or was the real "difficulty" simply the limited number of doctors with a capacity for only 50% of Dr. Edson's patients and the distribution being purely random as to who was to be the "haves" and the "have-nots"? This study will not be able to

definitively answer this question, but there are certain recurrent impressions. The most obvious of these is the time factor of when the family first sought a new doctor. As mentioned previously, it is clear that those who were the first to seek an appointment (usually as the result of acute need) often fared much better than those who waited longer to try to get an appointment. But this is certainly not wholly explanatory, and Table X offers some explanation as a listing of the way the patients who were successful found their new doctor.

TABLE X

Sources of New Physician in Patients Who Had Little Difficulty

1.	Member of family had been to doctor previously... (e.g.-during Dr. Edson's vacation)	4
2.	Close relatives of family were patients of..... doctor	3 (2)
3.	Friends were patients of doctor.....	3
4.	Nurse in the ICU at Griffin (Knew doctors well)..	1 (1)
5.	Miscellaneous..... (1 family needed appointment immediately after Dr. Edson left, July 10, and was accepted)	2 (1)
	Total	13
	Have not been to new doctor:	
	a) records supposedly with new doctor.....	1
	b) records unknown.....	1
	Adjusted total	15

( ) = Families in doctor's files cohort

The two families that had not yet been to a doctor present a problem. According to their statements of "difficulty" and their experience since Dr. Edson left, they fall into the "little difficulty" group and they have been so handled in the statistics in the study. Despite the relative certainty of one family, however, that they have a doctor if they need one "because their records are there," the experience of some of the "great difficulty" families showed that this certitude often becomes transientwhen the need for an appointment arises. The other family would seem to be in an even more precarious position since there is no knowledge of where their records are or if they are in the new doctor's files. This is not to say that they should not duly be considered to have had "little difficulty" because, indeed, they have had "little difficulty" thus far, but since the certainty of their relationship with their physician may be tenuous, they will not be treated comparatively in Table 10. Therefore, excluding these two families a trend seems to arise, viz. that over 50% of the families that were accepted by the new doctor had either had a member of the immediate family or a close relative previously cared for by that physician. This would not be unusual in a fairly homogeneous area such as the Valley where family ties are strong and there are thin lines between nuclear and extended families. And certainly it must be expected that in a competitive situation (into which this apparently developed) it "helped to have an edge," such as a sister who had been faithfully going to the "new" doctor for many years. The family of the nurse who "knew the doctors

well" also had a distinct advantage. Perhaps the most representative families are those who found their new doctor through friends, telephone book, or chance. These families total 5 or 39% of the 13 families in the study who have achieved a reliable relationship with the new physician. They represent, however, only 17% of all the families in the study, i.e., only one out of every six families who were faced with the loss of their primary physician established a reliable and permanent relationship with a new physician in six months with-out "great difficulty" and without having utilized an "advantage" (as described above). This does not change the fact that only one out of two families stated they had "great difficulty" with the transition, or imply that utilizing "advantages" is not honorable or "average." (It is not certain if the average, or representative, family would have entry to an "advantage.")

7. Comparison of medical care before and after retirement

Another method of approaching a similar issue was used and produced somewhat different results. The families were asked if they thought they could get (at that point in time) good care and prompt care and how this compared with their experience with Dr. Edson. The results are shown in Table XI and indicate, once again, that the dissatisfaction that did exist was not toward the "new" doctor. Indeed, it may be a tribute to the ten physicians among whom the thirty families were distributed as well as a testament to the fortitude of the families themselves that the vast majority thought their present care was as good as that they received from Dr. Edson. It is of note that many of the families of the "great difficulty" group fell in the undecided category because of limited or no experience with their "new" doctor (if any.)

TABLE XI

Assessment of Present Care by Patients

In answer to: Do you think you can get good care now? Can you get care quickly now

	Whole sample No.	%	D. F. C. No.	%	Whole sample No.	%	D. F. C. No.	%
Yes	24	80	7	23	22	73	6	20
No	1	3			3	10	1	3
Undecided	5	17	2	7	5	17	2	7
	30	100	9	30	30	100	9	30

	As good as before Dr. Edson left?				As quickly as before Dr. Edson left?			
Same	23	76	8	27	20	66	5	16
Worse	3	10			7	23	2	7
Undecided	4	14	1	3	3	3	2	7
	30	100	9	30	30	100	9	30

D. F. C. = Doctor's File Cohort

In summary, the patient's survey presents the following significant data:

1. All of the families desired a "generalist" to a specialist for their care
2. In 3 cases, there was a break in the continuity of care in chronic disease
3. Two-thirds of the families did not know of their doctor's retirement until less than a month before he left
4. Most learned of his retirement from Dr. Edson or through a one day notice in the newspaper
5. The longer the interval between Dr. Edson's leaving and the time when a family first needed medical care, the more difficult it became for them to find a new physician
6. Some families found that acceptance of their records by a physician did not insure their acceptance as patients
7. About one-half of the families encountered great difficulty after Dr. Edson retired
8. No agency or resource was available to assist the patients, although the hospital, health boards, and medical society were contacted
9. Only one out of every six families who were faced with the loss of their primary physician established a reliable and permanent relationship with a new physician in six months without "great difficulty" and having utilized an "advantage"

B) The use of the E.R. and other health resources

1. The use of the E.R.

The Emergency Room was listed as the "present" source of care by two families, #2 and #13, (one from each of the two cohorts), for the reasons enumerated in their statements. The availability of the E.R. at Griffin Hospital may have been very significant in the interim between Dr. Edson's leaving and the assumption of a family by a new physician and, as proposed in one of the study's hypotheses, there may have been both definite absolute and relative increases in the utilization of the E.R. by Dr. Edson's patients after he left. However, this was not able to be examined definitively within the scope of this study since one bias of the sampling procedure was that it insured that 21 of the 30 families had utilized the E.R. at least once in the six months prior to Dr. Edson's retirement. In actuality 27 of the 30 families had used the E.R. in that 6 month time period, since 6 of the 9 families in the "doctor's files cohort" had used the E.R. during that period. Although this latter group could possibly have been used as a "control" for E.R. use data, however, the data for this smaller cohort will be noted along with that for the whole sample. This bias, of course, would negate any purely statistical comparison between the utilization of the E.R. by the particular patient population represented by this sample before and after Dr. Edson left. Originally, it was planned to do a comparison with a control study with a random population picked from all the users of the E.R. in the same six month period, but this procedure was not deemed feasible at the time of the study. Instead, it was decided to simply observe what the patterns of the study's sample were, keeping

in mind its inherent bias. A broader, more accurate and more detailed study is certainly necessary in the future to adequately investigate the situation arising out of the complexities in the Griffin Hospital E.R. The problems surrounding Dr. Edson's patients' use of the E.R. are only symptomatic of the many situations that will be facing semi-urban community hospitals in the future as the adequacy of general primary care is questioned more and more. The data presented below are only brief facts relating to this group's use of the E.R. and it is outside the scope of this study to enumerate the ramifications of the data beyond presenting them. (It is hoped that this present study will serve to illuminate a few trends and problems, and that this possible clarification will then engender more definitive studies in the future.)

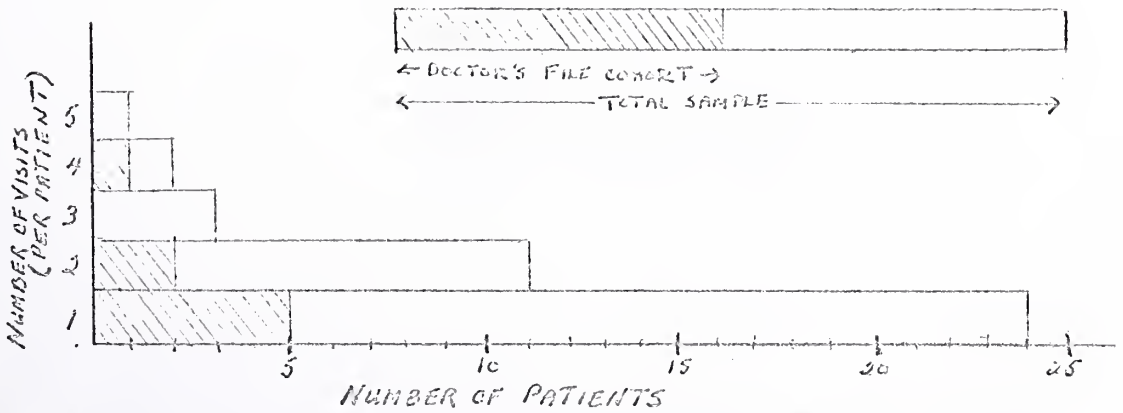
For the 30 families in the study (27 of which had at least one visit to the E.R.) 41 individuals used the E.R. "before Dr. Edson left." For the purposes of this question only, the time period "before Dr. Edson left" was not limited to the 6 months prior to his retirement, since, in the interview, the delineation between greater and less than six months was not practical. As it evolved, most of the E.R. visits enumerated were in the six months immediately prior to his retirement and all roughly within a year. Of the 41 individuals, 8 were from the "doctor's files cohort." The total of 41 individuals represents 30.6% of the total, and the 8 from the smaller cohort are 20.5% of that group. The average number of individuals using the E.R. per family in that period was 1.36 for the total sample and 0.89 for the smaller cohort (the more representative being the latter.) Of the 41 people using the E.R., there was a total of 68 visits (13 for the smaller cohort) "before Dr. Edson left" for an average of 1.7 visits per

person with at least one visit, 2.3 visits per family, and 0.5 visits per individual in the survey. For the "doctor's files cohort" the figures are 1.65 visits per person with at least one visit, 1.44 visits per family, and 0.33 visits per person in the cohort. Even this last figure is high for the expected number of visits per person in the area of 0.29 as calculated from the number of E.R. visits in 1969 (22,387)[29] and the population of the Griffin utilization area. This is most probably due to the small size of the sample giving statistical error, but may reflect greater use of the E.R. by Dr. Edson's patients, even before his retirement. From this data, though, this cannot be accurately assessed.

The 68 visits were divided by number of visits per patient as in Figure 7.

FIGURE 7

Number of Visits to E.R. Per Patient (Before Retirement)



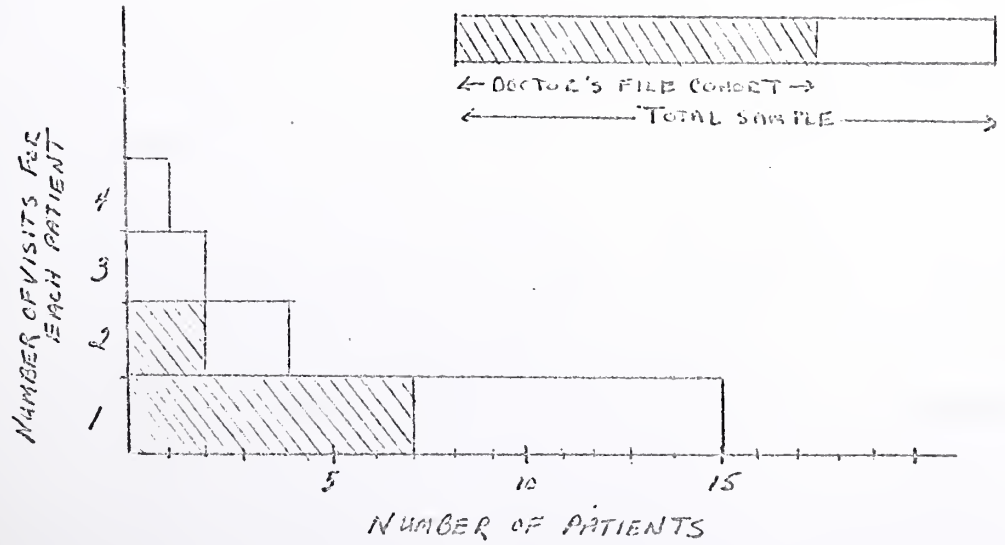
The breakdown of the diagnoses responsible for the E.R. visits before Dr. Edson's retirement is similar to that given in Solon's study[56] and seen in Table IV (i.e., trauma, G.I., respiratory, etc.) The majority

of the visits to the E.R. were not during regular doctor's office hours with only 18 of the 68 (26.5%) and, for the smaller cohort, 3 of 13 (23%) occuring during regular doctor's office hours. Thus, it would appear that, despite the bias of part of the population sample, Dr. Edson was the resource contacted in almost all cases, and the E.R. was utilized only when he was not available or when he referred the patient to the E.R.

In the six months following Dr. Edson's retirement, 22 people used the E.R. with a total of 33 visits. In the smaller cohort, 9 people had 11 visits. The breakdown of visits per patient is seen in Figure 8. These figures represent 0.25 visits per individual in the study per 6 month period and 0.28 for the smaller cohort. If this is converted to visits/individual/ year, the figures are 0.49 and 0.56, respectively.

Figure 8

Number of Visits to E.R. Per Patient (After Retirement)



Once again, the numbers involved do not lend statistical accuracy but definitely imply a significant increase in the utilization by the smaller cohort. Indeed, both groups are far above the expected value, but once again this could be a function of high utilization by Dr. Edson's patients in general, since they had a high rate before he left also. The expected use of the E.R. is based upon the number of visits between September, 1968 and September 1969, and it is probable that the rate of utilization for the general population increased in the time period September, 1969, to December, 1969. This, however, should not account for the absolute rise in number of visits of the "doctor's files cohort" and the "relative" rise in the "E.R. cohort" during the time period after Dr. Edson left (i.e., the "E.R. cohort's" rate of utilization did not decrease as much as it would be expected). One can only speculate that the data at hand signifies that the intervening variable in the absolute and "relative" increases in the two cohorts was the loss of the primary physician. Table XIV (Use of the Primary Doctor, Specialist, and E.R.) supports this hypothesis of an increase in use of the E.R. after Dr. Edson's retirement.

The distribution of E.R. visits between office hours and other times is similar to that before Dr. Edson's retirement with only 21.2% and 36.3% of the visits occurring during office hours for the whole sample and for the "doctor's files cohort" respectively. The answers to the question, "Would you have gone to Dr. Edson for this if he were still here?", were affirmative in 30 instances (91%) and negative in

3 (9%). This does not mean, however, that the E.R. would not have eventually been utilized in these cases anyway, but simply implies that Dr. Edson would have been consulted first. There was no significant difference between the time it took patients to be seen. The diagnoses responsible for the visits do not vary greatly from those for the visits before Dr. Edson retired and both are in accord with Solon's data. The reasons given by the patients for going to the E.R. before Dr. Edson retired (i.e., for not going to Dr. Edson even though he was still available) are seen in Table XII. The reasons given for going to the E.R. in general, and now that Dr. Edson had gone, are seen in Table XIII.

TABLE XII

Reasons for Visits to E.R. (Before Retirement)

1.	Referred by Dr. Edson	14 (8)
2.	Could not get Dr. Edson	14 (1)
3.	X-ray	13 (2)
4.	Not during office hours	11
5.	Lacerations	6 (1)
6.	Unconscious	1
7.	Job accident	1
8.	E.R. closer	1
9.	Met Dr. Edson at E.R.	1
10.	Miscellaneous	6 (1)
	Total	68 (13)

( ) - # from doctor's files cohort

TABLE XIII

Reasons for Going to E.R. (After Retirement)

1.	"Doctor unavailable"	17* (4)
2.	"Accidents" or "in an emergency"	14* (4)
3.	"Quick care"	2* (1)
4.	"On advice of Doctor"	2* (1)
5.	"Fractures" (X-ray)	1*
6.	"Insurance"	1* (1)
7.	"Stitches"	1*
	Total	38* (10) (more than one reason given per family)

* - # in whole sample
( ) - # in "doctor's files cohort"

The data in Table XIII is similar to that given by Alpert[2] seen in Table II. It is difficult to interpret these reasons, especially in contrasting those given before and after Dr. Edson's retirement. It is very significant, though, that 9 of the 30 families (30%) thought that they would use the E.R. for notably different reasons after Dr. Edson left as compared to before his retirement. Indeed, 43.5% of the reasons for going to the E.R. after Dr. Edson left (from Table XIII) were noted to be "doctor unavailable," in contrast to only 20.5% (from Table XII) before retirement if only "could not get Dr. Edson" is included and 36.7% if "not during office hours" is added.

It appears then that the E.R. played a significant role in the transition of many of Dr. Edson's patients to new health resources and was the eventual "health resource" itself for two of the families in the study.

Ancillary data that was compiled from the interview but is not directly related to the main focus shows that before Dr. Edson retired about 50% of the families waited for Dr. Edson to come to the E.R. and meet them instead of being seen by whomever was on duty. When asked generally whether they would prefer to see their own family doctor at the E.R., even at the expense of waiting, 60% still said that they would prefer the E.R. to be set up so the patient could see his own doctor. Twenty-nine of the 30 families felt that the care given in the E.R. is satisfactory, although one had "reservations" and two said "sometimes." Only one family was specifically dissatisfied with the care in the E.R.

2. The role of other health resources

The evaluation of the role played by health services at the place of employment found this to be of little significance. Of 37 employed people, 18 had health services available at their place of work and 13 used them, mainly for shop accidents and physicals. In only one case did the respondent note an increase in use after Dr. Edson's retirement.

Questions relating to the use of the clinic at Griffin Hospital found that this was not a significant factor in this situation.

3. Relative roles of family doctor, specialist, and E.R. (before and after retirement)

The final major part of the interview dealt with feelings of the patients toward the relative roles of the family doctor, the specialist, and the E.R. These opinions were elicited by posing a series of health problems and asking if the patient would have gone to Dr. Edson (a family doctor who did minor surgery) before Dr. Edson left and to whom he would go after Dr. Edson's retirement. The results are shown in Table XIV.

TABLE XIV

Use of the Primary Doctor, Specialist, and E.R.

Problem	Before 7/1/69-Dr. Edson?	After 7/1/69
1. "cut"	Edson-20 E.R.-10	New family doctor-15 E.R.-15
2. "Pain in stomach"	Edson-28 E.R.-2	New family doctor-24 E.R.-4 Unknown-2
3. "arthritis"	Edson-30	New family doctor-24 Unknown-4 Specialist-1 E.R.-1
4. "needed shots"	Edson-30	New family doctor-25 Unknown-4 E.R.-1

Table XIV continued

Problem	Before 7/1/69-Dr. Edson?	After 7/1/69
5. "Emotional problems"	Edson-26 Other-4	New family doctor-23 Psychiatric clinic-3 Unknown-2 Other-1 E.R.-1
6. "Needed a doctor at night"	Edson-27 E.R.-3	New family doctor-20 E.R.-8 Unknown-2
7. "Child with a bad sore throat" (only 23 with children)	Edson-23	New family doctor-19 Unknown-3 E.R.-1
8. "Pregnancy" (23 eligible)	Edson-18 Obs/gyn-5	Obs/gyn-10 New family doctor-8 Unknown-5
9. "Heart trouble"	Edson-27 Specialist-1 No answer-2	New family doctor-22 Unknown-3 E.R.-2 Specialist-1 No answer-2

Other than some interesting reflections on the role of the family doctor and the increased utilization of the E.R. after Dr. Edson left, this data shows a slight increase in the use of "specialists," mainly in obstetrics and gynecology. This is in accord with a question asking directly if there had been an increase in the use of "specialists" which showed 4 out of 30 families (13%) with increased use of specialists.

Slightly less than 50% of the families, evenly distributed between those who had "great difficulty" and not, "knew other people who had problems with health care since Dr. Edson left."

C) The experience of the doctors

The final part of the study dealt with the role of the primary physician in the Lower Naugatuck Valley and, specifically, the role they played in the transition period after Dr. Edson left. The attempt to delineate the problems faced by the primary physicians was thwarted by a very poor response to the query, which began as an interview of each primary physician and was soon changed to a written questionnaire in the hope of getting a better response. This was done in the manner described in Chapter 2. There were only 8 questionnaires returned (35%) of the 23 doctors considered to be primary physicians in the Valley. This, therefore, is certainly not a comprehensive study, but the results are still representative of the feelings of at least those who responded and, perhaps, may represent similar feelings in some of their colleagues. It is very unfortunate that the survey was not more encompassing but this in itself may indicate the isolated nature of the practicing physician in this area and the problems inherent in bridging this isolation by inducing cooperation and mutual interdependency.

1. Supply of physicians

Before describing the response of the primary physicians, however, it serves to note a few facts about them. The first of these is their number and what has been happening to this. The data is derived from the Griffin Hospital Medical Staff listings which is a dependable directory since any primary physician practicing in the Lower Naugatuck Valley would need Griffin Hospital for inpatient services. There was a total of 20 "general practitioners" in the

1970 Medical Staff listings. However, three of these were Dr. Edson and Dr. Wilbur Hansen (who died shortly after Dr. Edson retired), and Dr. Erwin Lenez,on leave of absence. In addition to those on the Medical staff are two "general practitioners" with courtesy privileges. There are also 2 pediatricians, 1 internist, and 1 surgeon that do a large part of primary practice (and are, therefore, in the category of specialists doing primary practice). Thus, about 32% of the active Medical Staff (with a 1970 total of 57), is composed of pure primary physicians and 40% if the "primary practice specialists" are included. Three of the "general practice" group were also Associates in Surgery, 5 were Associates in Obstetrics and Gynecology, 8 were Associates in Medicine, and one was an Associate in Pediatrics at Griffin. The relation of this breakdown of generalists (both full and part-time) to specialist to the distribution for Connecticut and U.S. (1966 figures) is shown in Table XV. It is obvious that the proportion of physicians in general practice is higher than that of the U.S. as a whole and much higher than Connecticut, reflecting the metropolitan nature of Connecticut, and the semi-rural pattern of physician distribution in the Lower Naugatuck Valley. One reason for this is the close proximity to New Haven, which, with its Medical Center, harbors a high percentage of specialists which are readily available to the people of the Griffin Hospital area. The only large areas in Connecticut that exhibit a similar generalist-specialist distribution are the Northwest, Northeast, and the Middletown areas (as defined by the C.R.M.P.) all of which are more rural

Table XV

PHYSICIAN DISTRIBUTION IN GRIFFIN HOSPITAL AREA (1970 FIGURES), CONNECTICUT. AND U.S. (1966 FIGURES)[11]

	Total Number of Griffin Area Physicians	Griffin Area %	Total Number of Connecticut Physicians	Connecticut %	United States %
Direct care of patients - private practice	52*	100	3,291	100	100
1. Full time specialty practice	30	57.7	2,442	74.2	63.8
2. General practice without specialty interest	18	34.6	563	17.1	
3. General practice with specialty interest	4	7.7	286	8.7	
4. Total general practice	22	42.3	849	25.8	36.2

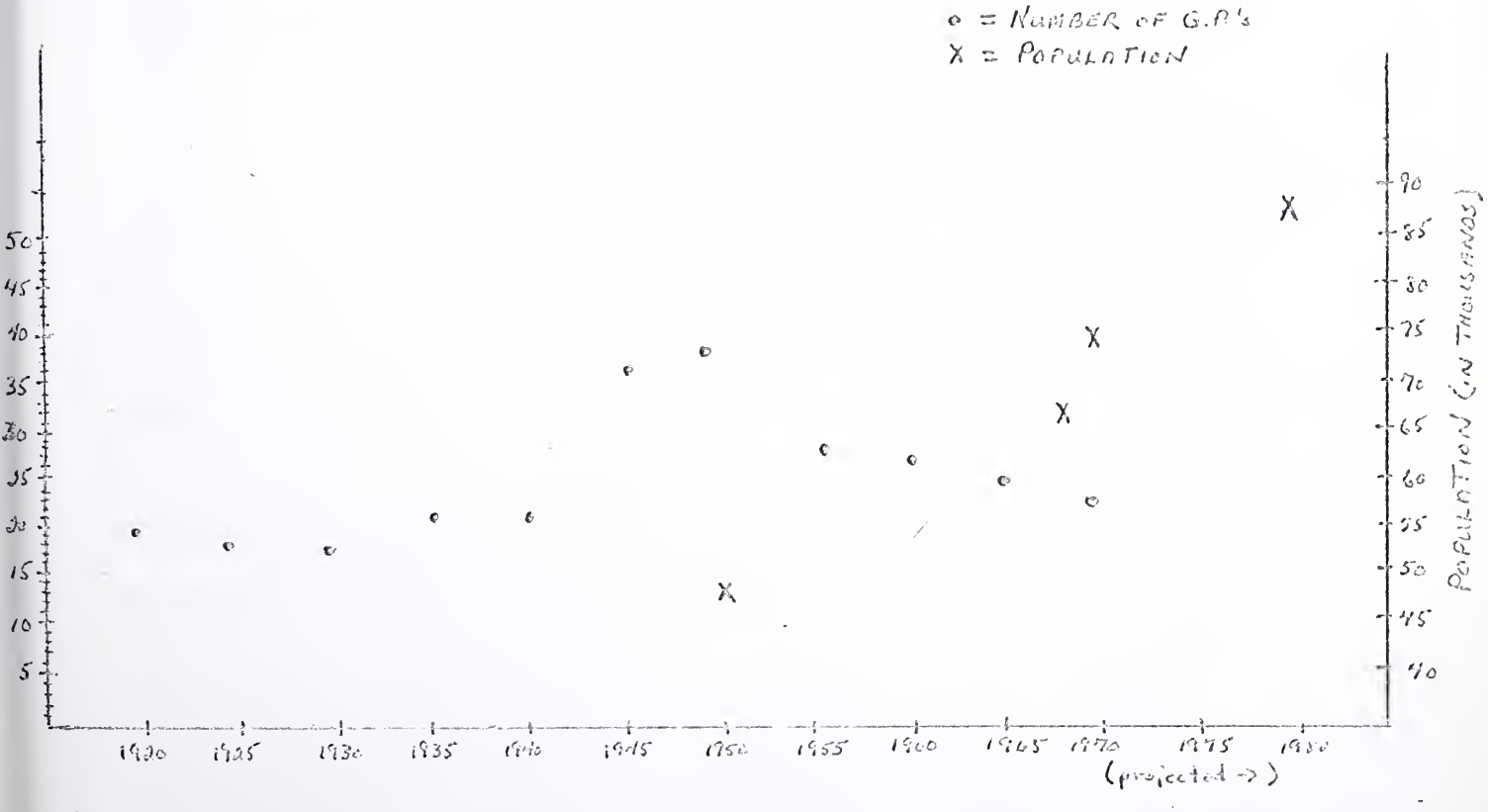
* Griffin Medical Staff without 2 dentists, 2 pathologists and 1 radiologist

than the Griffin Hospital area but are not equivalent geographical sections, (i.e.-their equivalent in the Lower Naugatuck Valley includes New Haven and Meriden, both of which would raise the percentage of specialists).

What is happening to this distribution in the Lower Valley area parallels the trends seen in Connecticut and the U.S. as a whole, viz., as specialism is increasing, generalism is declining. The actual number of general practitioners listed in the Griffin Hospital Medical Staff lists over the years is seen in Figure 9 (which, as explained above, is a good indicator.)

FIGURE 9

Number of G.P.'s on Griffin Hospital Medical Staff Lists: 1920-1970 and Population Growth in the Lower Naugatuck Valley: 1950-1980 (52)



During the five years 1965-1970 the total was affected by new physicians coming into the area, deaths, and retirements as seen in Table XVI.

TABLE XVI

Number of G.P.'s on Griffin Hospital Medical Staff Lists: 1965-1970

Year	Number of GP's
1965	24
1966	25 (1 new)
1967	26 (2 new, 1 deceased)
1968	25 (1 retired)
1969	25
1970	22 (1deceased, 1 retired, 1 leave of absence)

2. The experience of the doctors

With this background it would have been productive to analyze the problems touched upon in the interview schedule; as was detailed above, though, this is only partially possible. The data relating to the 8 "general practitioners" who responded will be presented only for its value for those 8 physicians since extrapolation is impossible.

The eight physicians estimated that they spent (an average of) about 90% of their time in "family practice" (undefined) and averaged about 16 hours/week "at the hospital." Four performed minor surgery and 4 performed no surgery. Seven performed no obstetrics and one delivered about 40 cases/year.

In regard to record-keeping, it is interesting to note that in answer to the question "About how many active patients do you serve?" 6 could not even give a rough estimate, one said 4-5,000 and the other,

1,500-1,800. In response to "About how many records do you keep on file, 2 did not know, 2 did not answer, 3 said 3-5,000 and one said "in the 100's". Five had no cut-off point for keeping "old" records, one said 10 years, one said 2 years, and one had not been in practice long enough. Six had inactive (or "dead") files for deceased patients and two simply mentioned that they kept them for 2 and 10 years, respectively. For patients who "left town", 5 handled it in the same way as an "inactive" file, 2 tried to forward it to the family's new doctor, and one response was illegible.

In reference to the transition itself, 6 of the 8 doctors were contacted by Dr. Edson about the possibility of assuming some of his patients, but no plans were made any more specific than that Dr. Edson would, e.g. "leave the records in the mailbox." No attempt at distribution was made, and, once again, there was no agreement by any of the physicians to assume any specific quota of Dr. Edson's patients (or, indeed, any at all). The number of Dr. Edson's patients requesting transfer to any one doctor ranged from 3 to 1,000. Most of those doctors that had less than 125 patients request transfer were able to take them all on, but the one physician with 1000 was only able to assume 3-400. All 8 doctors received the records of those families who had requested transfer to them before Dr. Edson left. Two doctors combined the transferred records with their own records immediately upon receiving them and the other 6 waited until the patients' were seen (if they were accepted). Two doctors had had communications with Dr. Edson concerning

his patients after his retirement, six had not. Six doctors felt that Dr. Edson's records were helpful in taking care of the new patients; two felt they were not. One doctor remarked that when one physician needs to use the records of another, it "probably is best to start from scratch and obtain records of hospitalization." When each physician was asked to describe or submit a sample record, however, the methods varied with each physician and often did not appear interchangeable (and as mentioned by one doctor, "Deciphering (Dr. Edson's records) first is the problem"). Two doctors said they would have preferred an "off-service" summary, while 5 thought it was unnecessary, and one did not respond (in only one instance, with the doctor who received the most cases, had there been any "off-service" notes at all). One doctor noted that the "off-service summary" he received consisted of a salubrious and appropriate "Good luck!" Seven doctors did not think there was a need for a regular system of transferring patient records, while one did.

In reference to the assimilation of Dr. Edson's patients, 3 doctors thought that the retirement of Dr. Edson had put a personal strain upon their particular practices, and these same 3 also felt that the new patients caused them to increase their office hours, and to reduce time they previously had for hospital rounds, house calls, and other non-office activities. None of the physicians, however, felt that there was any problem hindering their ability to care for the new patients in the same way as they cared for their "regular" patients, and all felt that the new patients got equal quality care and just as quickly

as their "regular" patients. Although the patient load of all but one of the doctors has been increasing, only two have a "closed" practice, i.e. do not take on new patients if they call for an appointment. One physician notes that with only a few more patients added to his practice there would be "a compromise" to the point of limiting "good" medical care. Three of the doctors felt that the new burden of Dr. Edson's former patients had put a particular strain on the remaining doctors in the Valley, three thought it had not, and two did not know. All of the doctors felt that primary care was necessary, and while some felt good medical care could be received through specialists alone, most felt having a primary physician was a definite advantage. One of the doctors noted that for the bulk of illness, going to a specialist would increase the cost of care without necessarily increasing the quality of care. Also, no specialist can serve the variety of general medical needs of a particular patient, so there is a decentralization of care with M.D.'s becoming less interested in the entire patient." A few noted the increasing importance of the E.R. but others looked upon both the E.R. and the hospital with skepticism. None of the doctors saw any real role for an "agency" to mitigate the problems imposed on patients and doctors by a situation such as the retirement or death of a colleague. This is, perhaps, the most significant result of the doctors' interview in light of the contrast between the unanimity with which they opposed any "intervention" into affairs which the doctors apparently feel is adequately met in more traditional methods, and the expressed feelings of about 50% of the families interviewed that these traditional methods were inadequate for them. There seems to be two

factors involved in the reasoning of the doctors: 1) an intrinsic dislike for interference into traditionally "medical" problems, and 2) for those who do not necessarily resent the "intrusion" of some system aimed at alleviating confusion and initiating cooperation, there remains the feeling that "systematizing" the presently unsystematized and fragmented non-union of health resources will, while sounding good on paper, do no real good in practice.

When asked about the role and development of primary medical care in the Valley area, answers varied from "fairly good" to "gloomy." The consensus, though, seemed to acknowledge increasing problems, at least as evidenced by a decreasing number of primary physicians with the population increasing, and saw the recruitment of more primary physicians as the only answer. One doctor noted that the hospital and community must take the lead in this. Another was more specific in defining the different areas of responsibility: "1) by the primary M.D.'s-upgrading of care, coordination of more efficient care facility, and continued education, 2) by the medical schools-interest, recognition and enthusiasm toward family practice, 3) by the hospital not to downgrade the family physician, to give him adequate privileges, committed work and recognition."

The answers to questions regarding coverage and use of written records and unwritten knowledge in patient care were too sporadic and vague to be of any value. This is unfortunate since these are both crucial areas in insuring continuity of care for patients.

D) A Summary of the Findings

The preceding presentation of data is put forth in the context of looking at an overall situation and presenting what happened through the eyes of a sample of those involved. On the part of the patients there is good reason to believe that the sample is representative of the total population; with the primary physicians, the sample may or may not be because of the inadequate response.

The focus of the study was upon the situations and problems surrounding the loss of a primary physician, in this case, by retirement. The methods employed were the personal interview of a selected sample of families who had lost the services of their family doctor six months previously and a questionnaire sent to the remaining primary physicians in the area. Much of the most important data is anecdotal, in the form of the statements of the families; there were many ancillary conclusions drawn and auxiliary data gathered which hopefully will lead to further investigation. The main findings, however, can be summarized in the following:

1. About one-half of the families encountered great difficulty after Dr. Edson retired
2. Only one out of every six families who were faced with the loss of their primary physician established a reliable and permanent relationship with a new physician in six months without "great difficulty" and having utilized an advantage
3. The mechanics of the retirement process did not work to the benefit of the patients.
4. No agency or resource was available to assist the patients, although the hospital, health boards, and medical society were contacted

The physician response was inadequate to draw statistically valid conclusions, but of those who did reply there were a few trends:

1. There was little or no planning done for the transition of the retirement
2. Some physicians were burdened by the disproportionate distribution of the families

3. There was little communication between the remaining physicians and the retired doctor after he retired
4. Some doctors felt the old records were not helpful, and would have appreciated "off-service summaries"
5. None of the physicians saw any role for an agency to mitigate the problems imposed on patients and doctors by a situation such as the loss of a primary physician

[This is in contrast to 50% of the families who felt that the traditional methods of dealing with such a situation had been inadequate for them.]

Research also revealed that there had been no prior investigation of this problem in the literature and there were little or no guidelines supplied by the A.M.A. or state and local medical societies regarding procedures to be followed in situations such as the one under study. There was no retrievable data on the procedures utilized by retiring physicians or on the legal aspects of disposition of a practice at the death of a physician.

These findings lend another dimension to the well-recognized problems of the shortage of doctors, especially family physicians. They also shed light on traditional professional attitudes and some of the impediments that these attitudes might occasion. They mostly serve to highlight, however, the inadequacies of the present methods of dealing with the loss of a primary physician and the need for the development and implementation of procedures that would be more advantageous to all involved and would particularly mitigate the hardship caused to the patients by the loss of their doctor.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

The situation that was analyzed was, in one sense, a problematic one, viz., was hardship incurred by the loss of a family physician? The main hypothesis was that it was, and the method utilized to validate this was not to prove that X% of the population did or did not encounter "X" number of difficulties. These figures were presented as a coordinating factual experience, but the real importance of the results was the finding that a certain proportion of the families involved, in this case about half, had "great difficulty". This was expected, and found through experimental procedure to be the case.

The reasons for the difficulties mentioned were not clearly delineated and in themselves probably encompass most of the significant problems in the delivery of health care in the U.S. The most obvious and one of the more impregnable dilemmas is that of the shortage of physicians generally and primary physicians, in particular. The data presented above implies that while the Lower Naugatuck Valley is enduring the same pressure of increasing population without concomitant increase in physicians, this pressure is no more acute than in most of the U.S. Undoubtedly, if more physicians had been readily available, many of the critical problems could have been deterred. This situation, then, is one of many that point to the need for increased medical and para-medical personnel in general and, specifically, in the Valley. The problem of imbalanced distribution of medical resources has been extensively studied and several remedies have been suggested (in the forms of military deferment, different emphases in medical training, financial

and habitation incentives, etc.) The recruitment of physicians by competing communities at times asswmes epic proportions, but in some is negligible or amateurish. The most seasoned recruiting source is the American Medical Associations' Placement Service which was started in 1944 to assist medical officers returning from the armed services and now serves physicians with the stated purpose "to put you (the physician) in touch with those seeking the type of medical service you are prepared to offer." Appendix D is a direct extraction from the booklet published by the A.M.A.'s Placement Service called "Finding a Place to Practice"[20] and deals with those priorities to be considered in selecting an area to practice. The reason for mentioning this service is not to dwell on the significance of physician shortages and placement, but rather to emphasize the benefits that arise from an agency that has a function not of increasing the absolute number of resources but of joining resources to needs. If one impression can be sustained from this study, it is that, in addition to a need for more medical personnel, there is a need for an agency to mitigate the problems of the patient in finding new resources after the loss of a primary physician, whether through the death, disability, or retirement of the physician or the change of residence of the family. (The latter situation may be more numerous quantitatively, especially in areas of high transiency, but do not present the total impact on one community that a loss of a physician does. A solution to the communications problem in one situation, however, may serve a similar function in the other area.)

Here it is best to return to statements made by some of the families at the end of the interview when they were asked if they had any further comments or suggestions than those already discussed. Their conclusions may, in turn, be those of the study.

> "(Dr. Edson) should have notified patients personally by a note and recommend a new doctor. Also, someone like the Board of Health should make sure that patients all get doctors. If the Hospital finds that a patient does not have a doctor they should notify the Board of Health and get a doctor or a visiting nurse. Now I have no idea of where to go for help."
>
> "The doctor should give you a list of names of other doctors when he retires and make sure that your records are transferred, not just left and burned."
>
> "Someone should take care of that gap between old and new doctor; there should be some clinic or something. Also, the Public Health nurse could be used."
>
> "The Medical board should have handled it."
>
> "The hospital would be a good central point to contact and help patients and act as a clearing house."
>
> "There should have been something set up to take care of the patients because it's kind of rough for patients who've had one doctor all their life to be left with out one."
>
> "There should be somebody to help people find new doctors, especially older people with problems of transportation, etc."
>
> "The local medical society should have some way of helping in the organization."
>
> "You can't just drop all those patients without having some place for them to go. There should be somebody who can help me find a doctor, e.g. the hospital-there should be somebody caring about these patients who were left out in the cold, even to just have called Dr. Edson's patients and asked how they were doing."
>
> "There should be some central place to keep records so that the new doctor could get them rather than having them disappear."

> "This is a significant problem. I called Griffin and they didn't know anything. Then I called the Boards of Health in the various towns with similar results. They should combine the Boards of Health into a District Health Officer, to whom the doctors would be responsible. The problems of the patients are the hospitals or Board of Health's responsibility."

These and other similar statements serve to corroborate the major conclusion of this study that, indeed, there should be an "agency" to assist people in such a situation. It is important to note the intransigence of the physicians at the suggestion of such an "umbrella agency" and to consider the feelings of the physicians in any plans for coordination, since they would be among those coordinated. It is important, however, that this attitude of individuality and self-sufficiency not be at the expense of the patients. It is not the purpose of this study to define "how" such an agency should be organized, but mainly that it is necessary. Indeed, any attempt at setting up structural relationships would have to incorporate a temporal flexibility that this one writing cannot effect. For the sake of completeness, though, the following suggestions can be made:

1) The recognition by national, state, and local medical societies, hospitals, Boards of Health, Health Departments, and associated health agencies of the need to assist patients in obtaining assistance and negotiating the health care maze.

2) The coordinated effort of the above-named groups to establish a local point of reference at the community level that would serve as an intermediary in helping patients to locate existing health resources.

3) The adequate publication of this facility so that those in need of its services would be aware of it, i.e., telephone directory, hospital, and doctors' offices. (There exists no such reference in the Lower Naugatuck Valley; however, there is a number listed in the Greater New Haven telephone directory (not including the Valley) which "in an emergency" connects the patient with the doctor's answering service. There is no guarantee that a doctor will be located by this procedure. This is a service of the New Haven (City) Medical Association.

4) The identification of this "agency" with an established and respected organization in the community in which the people have confidence (e.g., the hospital or community health board).

5) The knowledge by this "agency" of all existing health care resources, the geographical distribution, specialty interest or particular function, size of practice and age of physician, coverage procedures, hospital affiliation and access to other referral services, and availability of entrance into practice (i.e., which practices are "open" and to what "type" of patient e.g.-pediatric, surgical, etc.) (The New Haven County Medical Society (including the Lower Naugatuck Valley) makes available the names of three physicians in a specialty when asked by a patient. There is no other data given, and no assurance of openings in the practice. Similarly, Griffin Hospital will give a list of physicians in the area in a certain specialty).

6) The full cooperation of the physicians of the area with each other and this "agency" in establishing a plan of disposition of a doctor's patients upon his unexpected death or disability and, in the case

of retirement known in advance, adequate provisions for a smooth transition at the time of retirement made well in advance of that date.

7) Adequate assistance by this agency to the family of a deceased physician if they are burdened with 1) disposition of patient records, 2) notification of patients, and 3) temporary coverage of patients. (If this is accomplished efficiently, the family need not be burdened at all with these problems which they are probably not equipped to handle and certainly not inclined to do in such a time of stress. The A.M.A. national office offers no assistance or information in this area to families of deceased physicians. The Connecticut State Medical Society has published a booklet entitled "Set Your Affairs in Order"[54] which offers some advice in this area. It is significant that this is the only guideline relating to the problems that is available to physicians and their families, and that the only mention it makes of patient transferral is the following:

> "Some arrangement with a colleague should be made immediately in regard to patients in the hospital. While not required, it would be a courtesy to be able to suggest a colleague to other patients.")

8) The establishment of guidelines by national and state organizations for the procedure to be followed when a physician retires regarding: 1) notification of patients (when, how, etc.), 2) transfer of patients to new health resources, and 3) cooperation with the "agency" that would be helping his patients. (No guidelines presently exist.)

9) The establishment of guidelines for the handling of patient's records at the termination of a doctor's practice, especially regarding custody, remuneration, transcription, and dispersal. (The few statements that presently exist are vague and often contradictory. The pamphlet mentioned above states in regard to patient records:

> "The contents of such records should be disclosed to another physician of the patient who so requests. Such a request should be in writing and should be retained with the records. Normally, the records are confidential and diagnostic information in them should not be disclosed directly to the patient because of the risk that he might misinterpret them. All patient's records should be kept for about six years. Records of patients who were minors when treated should be preserved until two years after the patient reaches twenty-one. When possible records can be microfilmed and stored indefinitely. This is not a large cost.)"

10) The establishment of guidelines for mutual on-going coverage of doctors in solo practice on off-duty hours and vacations. (Without such coverage the patient is confronted with a microcosm of the larger problems with which this study deals. The two situations are mutually inclusive and a remedy for one may benefit the other.)

11) The definition of procedures for office record-keeping as comprehensive and extensive as those described by Weed[63] for hospital in and out-patient records. (This is one of the more pressing problems in the organization of primary care, since as evidenced by the statements of some of the physicians in this study, one doctor's records are often meaningless to another because of dissimilarity in content, tone, and completeness or illegibility. In a referral situation, the referring doctor (usually a primary doctor) can encapsulate the patient's pertinent

data and relate it verbally or in a short memo, thus obviating in part the need for consistency of record-keeping. But with the loss of the primary physician, he is not able to summarize the pertinent data, and it must, therefore, be easily extractable from his records. With a retiring physician, an "off-service" summary containing information related to special problems or to the general knowledge of the patient that makes him different than, for example, The E.R., certainly appears desirable. With present systems of record-keeping this would seem an overwhelming task if this is to be done for several hundred families. However, a centralized record system utilizing dictation by phone, computerization, microfilm, and immediate retrieval is becoming more of a reality for service areas the size of the Valley and "off-service" summaries would be more feasible in this situation.)

12) For the Lower Naugatuck Valley in particular, plans for regionalization and defragmentation of health services to proceed as rapidly as possible. (The Chamber of Commerce has had a Committee to Study a Regional Health Department for five years. Now C.D. A.P., the Valley Regional Planning Agency, the Community Council, and the Valley Council of Elected Officials are all interested in a regional health department and are developing data to be used in pursuing such a facility. Whether this health department would disclaim involvement in problems of "personal health care" as done in effect by the New Haven Department of Health is not apparent, but it is probable that political pressure, including that from the medical society, will be a determinant of its course. In any event, regionalization will be an improvement over the existing situation.)

13) For the Griffin Hospital to recognize its role of leadership and responsibility in the Valley and to utilize the leverage that it can exert to galvanize the physicians in the Valley around issues important to both patient and doctor.

14) The establishment of comprehensive group practices in the Valley. (This is, ultimately, the most realistic of possible alternatives, and an eventual necessity if comprehensive, high-quality primary care is to be made available to patients.)

The above suggestions are practical approaches to the problem discussed in this study which is important not only in its own right but also as a symptom of more pervasive problems in health care. The most accurate assessment of these problems was perhaps stated by the patient who observed, "Whoever is in charge of the doctor business should tell you where to get a doctor." It was to underscore the fact that nobody was in charge and some of the patients in this study were not "told where to get a doctor" that this study was undertaken. It is written in the hope that future and existing health services can decide who is in charge and that the patient will be the beneficiary of this organization.

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Doctors' Interview

Name.....

Specialty interests listed in A.M.D.

Other information listed in A.M.D.

Solo practice.....

Partnership of 2.....

Partnership of 3.....

Other.....

Hospital privileges: .....

A Content and nature of practice

(1) Very roughly, what proportion of your practice do you spend in primary or "family practice?"_____ and what in "specialty or other types of practice?"_____ Would you briefly describe the content and nature of the practice you do?

(2) How much time per week do you spend in the hospital?

_____

(3) How much surgery do you perform?_____

(4) How much obstetrics do you perform?_____

B Extent of practice and practice records

(1) About how many active patients do you serve? _____

(If in partnership, describe how many patients are served by the total practice and how the patients are assigned to each partner.)

(2) About how many records do you keep on file? _____

(3) a) Do you have a cut-off point for keeping old records? (5 years, 10 years?)

b) What happens to the record of patient who dies?

c) What happens to the record of a patient who leaves town?

(4) May I have a copy of your record form?

(5) Did Dr. Edson contact you concerning the possibility of your assuming some of his patients when he retired? _____

(If so) When? _____

Were any agreements on plans made? _____

Were any plans made for the transfer of records, specifically? _____

(6) How many of Dr. Edson's old patients requested to be transferred to you? _____

(7) About how many were you able to assume as regular patients? _____

(8) When did you get the records of Dr. Edson's patients? _____

In what manner did you receive Dr. Edson's records? _____

(9) Did you combine them with your files when you received them or wait until the patients requested to see you? _____

(10) Have you had any communication with Dr. Edson since his retirement concerning his old patients? _____

(11) Were Dr. Edson's records helpful to you in taking care of the patients who came to you? _____

(i.e. can one physician in private practice use the records of another, or do you really have to start again from scratch?)

(12) Were Dr. Edson's records similar to your records in form and type of content? _____

(If not) Was it necessary for you to transcribe them? _____

(13) Would you have preferred some sort of "off-service" summary of the patients history and condition? _____

Has there been "off-service" notes by Dr. Edson on the patients you have seen? _____

(14) Do you think there is a need for a regular system of transferring patient records? For example, would you have preferred some other manner for the patients to be transferred? _____

C Assimilation of Dr. Edson's patients

(1) Do you normally take on new patients, if they call for an appointment? _____

If not, to whom do you refer them?

(2) Has your patient caseload been increasing? _____
(If so) Do you think that these increasing numbers put any added limitations on your patient services that you wish were not there?

_____

(3) Do you think the retirement of Dr. Edson (or the loss of an functioning primary physician) has put any personal strain upon your particular practice? _____

(4) Do you think the assumption of Dr. Edson's patients reduced the time you had previously for hospital rounds, house calls, or other activities? (i.e. did it cause you to increase your office hours?) _____

(5) Was there any problem in your ability to care for these new patients in the same way you care for your regular patients?

_____

(6) Do you feel that the new patients get equally as good care as your regular patients? _____

(7) Do you feel that the new patients get care as quickly as your regular patients? _____

D The problem of assimilation in general

(1) Do you think the new burden of Dr. Edson's old patients has put a particular strain on the remaining doctors of the valley?

_____

(2) Some of Dr. Edson's patients have undoubtedly shifted from primary physicians to self-referral to specialists. If so, do you feel that they can get the same type (quality) of care that they got before? (i.e. what values do you yourself place upon primary or family care?)

(3) What role do you think the hospital (through the E.R., clinics, etc.) does play--and should play--in relation to the problems of Dr. Edson's patients?

(4) What role would you see for some type of "umbrealla" agency that would help doctors, and patients in the future in the event of the loss of a Doctor's services through retirement or death?

E Future of primary care services in the Valley

(1) Would you comment in general about the role and development of primary medical care in the Valley?

(2) What can be done to make primary services better?

(3) By whom?

F Miscellaneous

(1) To what extent do you rely upon your records for knowledge of your patient?

(2) To what extent do you rely upon your unwritten knowledge of your patient?

(3) Would you accept as a new patient someone you see while (if) you are on duty in the Emergency Room who needs a family physician?

(4) What arrangements do you make for your patients to be covered when you are not available (vacationing, day off, etc.)?

(5) Approximately what percentage of your practice is composed of "welfare" patients and how would you define "welfare" in this case?

Patients' Interview

Name of person interviewed_____
Occupation of household head_____
Education_____
High School/no diploma _____
High School/diploma_____
College (Specify # of years)_____

1. How many people are (living with you) in your family and what are their ages?
2. Which of your family members used to see Dr. Edson as his/her regular doctor?
3. For each person in your family, do you think he or she has needed the same, or more or less, medical care than before Edson left?
4. Who in your family has been to a Doctor since Dr. Edson closed his office, which doctor, how many times, and for what reason?
5. If Dr. Edson were still here would you have gone to him for this?

Name	Age	Saw Dr. E.	Same more or less	Been to Dr. since 7/1	Which Dr.

How many times	Why	Edson still here

6. Does anyone in your family have any special health problems?

_____

7. Did anyone in your family have any chronic problems that Dr. Edson was taking care of? Was there any break in this care when Dr. Edson closed his office?

_____	_____	
_____	_____	If yes, what was this due to?
_____	_____	
_____	_____	

8. Had anyone in your family been seeing any other doctor before Dr. Edson closed his office? For what reasons? Were you referred by Dr. Edson?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. How did you find your new Doctor (s)?
Did any one help you? Did Dr. Edson refer you?

10. How long did you have to wait to get an appointment, if one was needed?

11. How long did you usually have to wait for an appointment?

Drs name	Way found	Referred by Dr. E.	Wait for apt	Wait for apt. with Dr. E.

12. Do you prefer the members in your family to be taken care of by a general practitioner or a specialist?_____

13. Has your family's use of specialists changed since Dr. Edson left?_____

If yes, How?_____

14. Did you ask Dr. Edson to refer you to another Doctor?_____

_____

15. How did you hear about Dr. Edson's retirement?_____

_____

When was this?

at least a month before he retired_____
less than a month_____
after he retired_____

16. Did any member of your family use the Emergency Room before Dr. Edson left?
17. How many times and for what reasons?
18. Was it mostly at night or on the weekend, or during regular doctors office hours (i.e.-during the day)?
19. Why didn't you go to Dr. Edson for these problems?

Name	#of visits	reasons	during office hours yes	during office hours no

Why not Dr. E.

20. Has anyone in your family used the E.R. since Dr. Edson left? How many times? For what reasons? During office hours? Would you have gone to Dr. Edson for this? How long would it have taken to see Dr. Edson for the same problem? How long did it take in the E.R.?

Name	#of visits	reasons	during office hours, yes	no		would have seen Dr. E.

How long with Dr. E.	How long in E.R.

21. In general, why would your family go to the E.R.?

Is this different than before Dr. E. left?

22. When you used the E.R. before Dr. Edson left, did you have him come to the E.R. or did you just see the doctor on duty?

23. Would you prefer the E.R. to be set up so that you see which ever doctor is on duty, or so that they call your own doctor to treat you when you get there?

24. Do you feel the care given in the E.R. is satisfactory?

25. Did anyone in your family use the clinic at Griffin Hospital before Dr. Edson left? How many times? For what reasons? Why did you not go to Dr. Edson?

Name	#of visits	reasons	why not Dr. E.

26. Has anyone in your family used the clinic at Griffin Hospital since Dr. Edson left? How many times? For what reasons? Why did you not go to your family doctor?

Name	# of visits	reasons	why not family doctor

27. How long did you have to wait to get an appointment at the clinic?

How long did you have to wait in the clinic?

Do you think the care given in the clinic is satisfactory?

30. Is anyone in your family employed? Do they have health services provided at the place of employment? Did you use them before Dr. Edson left (i.e. - in place of seeing Dr. Edson)? For what reasons? Did you use these services change when Dr. E. left?

Name	Health Services Provided		Use them before Dr. left
	Yes	No	

Reasons	Change in use

31. Was the change between Dr. Edson and what ever health services you are using now difficult for your family?_____

If yes, why?_____

32. If someone in your family had a health problem now, whome do you call? Do you think you can get good care? As good as before Dr. Edson left? Can you get care quickly? As quickly as with Dr. Edson?

Who called?_____

Get good care?_____ better_____ same_____ worse_____

As good as Dr. E?_____

quickly_____ quicker_____ same_____ slower_____

as quick as Dr. E._____

33. How long had you been using Dr. Edson?

_____

34. Has anyone you know who used to go to Dr. Edson had problems with health care since Dr. Edson left?_____

35. If someone in your family had gotten a cut that needed attention before Dr. Edson left, what would you have done?_____

Now?_____

36. If someone in your family had a "pain in the stomach" before Dr. Edson left what would you have done?_____

Now?_____

37. If someone in your family had arthritis before Dr. Edson left, what would you have done?

_____ Now?_____

38. If someone in your family needed shots before Dr. Edson left, what would you have done?

_____ Now?_____

39. If someone in your family had emotional problems, would he have gone to Dr. Edson?

_____ Now?_____

40. If someone in your family needed a Doctor at night before Dr. Edson left, what would you have done?_____ Now?_____

41. If your child had a bad sore throat before Dr. Edson left what would you have done?

_____ Now?_____

42. If someone in your family was to have a baby before Dr. Edson left, where would she have gone?_____ Now?_____

43. If someone in your family had heart trouble before Dr. Edson left, what would you have done?

_____ Now?_____

44. Do you have any recommendations about the way patients could be handled when a doctor retires?_____

45. Do you have any other comments or questions?_____

_____

_____

D
R
A
F
T

Dear_____

This is an unusual but important request to assist a group of doctors and Griffin Hospital is understanding an increasing medical problem and recommending a solution.

We would like to have our representative, William Toms, interview you at your convenience on one of the most important health problems that confronts people today-what to do when you lose your family doctor through retirement, disability or death.

This has been a particular problem recently in the Valley with the unfortunate death of Dr. Casagrande and the retirement of Dr. Edson. We are investigating, therefore, some of the problems that patients and doctors face during this change, with the hope that we can develop some idea of how the change can be made as easy and effective as possible in the future. We are working in close cooperation with Dr. Edson, the other doctors in the Valley, and the hospital, and are interviewing former patients of Dr. Edson's to learn of their experience.

Your family was chosen by chance along with 50 others from approximately 3,500 names. We feel that your answer would be representative of many others and we would be very appreciative if you could participate by making a date for an interview with Mr. Toms, when he calls you in the near future. With the data

collected from you and the other families we will be interviewing, we hope to get a clear picture of some of the problems faced by people when they loose their doctor, and then, what can be done to help them receive the best medical care possible.

The project is under the guidance of a very special program at Griffin in Community Health which is the out-growth of a 3 year Federally funded Health Education Demonstration Project. Your responses will be treated confidentially in that no names or other identifying personal information will be used in reporting our results. This investigation is a unique one in the country according to the experts.

We hope you will enjoy this opportunity and look forward as much as we do to seeing the results.

Sincerely,

Richard K. Conant, Jr.
Director, Health Education Project
Griffin Hospital

Factors to Keep in Mind

Geographic location is probably one of the first considerations which will enter your mind. Unless you have personal reasons such as strong family preferences for one locale, however, this may well turn out to be one of the least important factors. What you want to do is match your wants-personal, professional and economic-with a community and opportunity which most closely meets them. Here is a check list of some of the questions you might want answered as you narrow your choices.

Community Need

1. Number of physicians in the trade area? Specialties?
2. Ages of nearest practicing physicians?
3. Where do people now go for medical care?
4. If the community is without a doctor, how long has it been without one?
5. Why did last physician leave?
6. Economic structure and dependability of community- is it dependent on one or a seasonal industry? What is the trade area?

Desirability of the Location from Your Family's Point of View

1. Will your wife be happy in the community?
2. Do the facilities for your family life include satisfactory housing, good schools, and the church of your preference?
3. Are there other professional people in the community? Adequate social opportunities in the way of women's organizations and fraternal organizations?
4. Are recreational opportunities available for the kinds of activities you and your family prefer and are accustomed to?
5. What is the distance to the nearest large shopping center or area?

Desirability From a Professional Standpoint

1. Office Facilities
   a. Is a site available?
   b. Is it in a desirable, accessible location with adequate space for parking?
   c. Is the rental or purchase price reasonable
   d. What about equipment?
2. Hospital and Medical Facilities
   a. How far away is the nearest hospital?
   b. Is staff membership open or closed?
   c. What about its facilities and equipment?
   d. Is the county medical society active?
   e. How about the accessibility of other services and opportunities? for instance, pharmaceutical, post graduate education, consultation services?
3. Supplemental Income - Can you supplement your practice income from:
   a. Industrial work?
   b. School health programs?
   c. Insurance examinations?
   d. As public health officer, coroner or city physician, or assisting police or fire departments?
   e. Nursing home services?

Miscellaneous Factors

1. What is the situation in reference to the population trend? Sources of income in the community? Climate? Transportation?
2. Are your attitudes, nationality, and family background reasonably compatible with those of the community?

Conclusion

In the final analysis, you should visit personally any location which you are seriously considering. Only by doing this will you be able to draw together and weigh all tangible and intangible factors which will help determine whether you want to settle there permanently.